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FISCAL YEAR 1990 BUDGET ISSUES RELATING TO GRADUATE MEDICAL EDUCATION AND ITS SUPPORT UNDER THE MEDICARE PROGRAM

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FIRST CONGRESS

FIRST SESSION

APRIL 11, 1989

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FISCAL YEAR 1990 BUDGET ISSUES RELATING TO GRADUATE MEDICAL EDUCATION AND ITS SUPPORT UNDER THE MEDICARE PROGRAM

TUESDAY, APRIL 11, 1989

House of Representatives,
Committee on Ways and Means,
Subcommittee on Health,
Washington, DC.

The subcommittee met at 9:40 a.m., in room B-318, Rayburn House Office Building, Hon. Fortney Pete Stark (chairman of the subcommittee) presiding.

[The press releases announcing the hearing follow:]

FOR IMMEDIATE RELEASE
THURSDAY, MARCH 16, 1989

PRESS RELEASE #7
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE FORTNEY PETE STARK (D., CALIF.), CHAIRMAN, SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES, ANNOUNCES A HEARING ON FISCAL YEAR 1990 BUDGET ISSUES RELATING TO GRADUATE MEDICAL EDUCATION AND ITS SUPPORT UNDER THE MEDICARE PROGRAM

The Honorable Fortney Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will hold a hearing on fiscal year 1990 budget issues relating to graduate physician education and its support under the Medicare program. The hearing will be held on Tuesday, April 11, 1989, beginning at 10:00 a.m., in room B-318 Rayburn House Office Building.

In announcing the hearing Chairman Stark said, "Medicare will invest over $3 billion in support of physician education programs in fiscal year 1990. It is essential that we review the value of that investment, while keeping in mind the 'safety net' role that teaching hospitals play in providing critical care to the medically indigent."

Oral testimony will be heard from invited witnesses only. However, any individual or organization may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing.

BACKGROUND

Medicare supports graduate medical education in two ways. First, additional payments are made under the hospital Prospective Payment System (PPS) for the indirect costs of graduate medical education programs. These costs may be due to the extra demands placed on the hospital staff as a result of teaching activity or additional tests and procedures that may be ordered by residents. Patients treated in teaching hospitals are likely to be more severely ill than average and more likely to be indigent, factors which also lead to higher cost per case.

The additional payment is based upon a formula that provides an increase of approximately 7.7 percent in the diagnonis-related group (DRG) payment. The payment increases with the ratio of a hospital's interns and residents, to its bed capacity.

The President's budget proposes a decrease in this factor to approximately 4.05 percent.

Medicare also pays for the direct costs of physician graduate education, and training for nurses and allied health professionals (such as the salaries of trainees, teachers, supervising physicians, and classroom space) on a cost-based, pass-through basis. Payments for the training of physicians are limited by a formula tied to the Consumer Price Index. The President's fiscal year 1990 budget for physician training would exclude costs other than those related to the salaries of interns and residents from the calculation of direct payments.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

For those who wish to file a written statement for the printed record of the hearing, six (6) copies are required and must be submitted by the close of business on Friday, April 21, 1989, to Robert J. Leonard, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, 1114 Longworth House Office Building, before the hearing begins.

SEE FORMATTING REQUIREMENTS BELOW:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will **not** be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.
4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and public during the course of a public hearing, may be submitted in other forms.

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* * * NOTICE -- CHANGE IN TIME * * *

FOR IMMEDIATE RELEASE
THURSDAY, MARCH 30, 1989

PRESS RELEASE #7-REVISED
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE FORTNEY PETE STARK (D., CALIF.), CHAIRMAN, SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES, ANNOUNCES A HEARING ON FISCAL YEAR 1990 BUDGET ISSUES RELATING TO GRADUATE MEDICAL EDUCATION AND ITS SUPPORT UNDER THE MEDICARE PROGRAM

The Honorable Fortney Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced that the hearing on fiscal year 1990 budget issues relating to graduate physician education and its support under the Medicare program scheduled for Tuesday, April 11, 1989, will begin at 9:30 a.m., instead of 10:00 a.m. as announced earlier.

All other details for the hearing remain the same (see press release #7, dated March 16, 1989).

* * * * *

Chairman STARK. The Subcommittee on Health of the Committee on Ways and Means will continue its hearings on fiscal year 1990 budget issues with an examination of payments in support of graduate medical education.

For too long, the discussion on GME in the committee has tended to focus on the narrow set of topics surrounding the methodologies used to reimburse teaching hospitals for the cost of teaching. I would submit that with expenditures for Medicare's indirect teaching adjustment scheduled to reach $2 billion this year, while direct medical education will consume $1.5 billion it's time we asked what we are buying.

Today's hearing will focus on these larger questions. We appear to have a health care delivery system characterized by an overall surplus in physicians and a shortage of primary care practitioners. At the same time, many areas of our country, particularly inner-city and rural communities, cannot attract sufficient physician manpower.

The question we need to ask first is what role can the Nation's graduate medical education programs plan in resolving these issues? And, second, we should ask what role can Medicare's reimbursement of education play in bringing about desired changes in graduate medical education.

We have to take into account the fact that most of our major teaching hospitals are also the inner-city hospitals which provide the larger share of uncompensated care to our poorest citizens. Substantial reductions in payments may weaken the safety net that those hospitals provide to some neighborhoods in this country.

At the same time, hospitals are not created with an inalienable right to create and maintain teaching programs and to receive extra reimbursement as a result. If there are too many programs, or they're not training the right types of doctors, it is my view that the Medicare Program has the right to take those issues into account in its support of graduate medical education.

I would further state that I have always been confused as to just how graduate medical education came to become the sole province of the Medicare system. That's a certain amount of legislative legerdemain that has escaped me and predated my tenure. I would be the happiest of all people if some other committee in the Congress would decide to take that responsibility on its shoulders and let us get on about the business of providing acute medical care to the 32 million Medicare beneficiaries.

But, as we are by default in that position, I am sure this committee will continue to accept the responsibility and to do the best we can.

[The statement of Mr. Stark follows:]

OPENING STATEMENT
Honorable Fortney Pete Stark
Chairman, Subcommittee on Health
Committee on Ways and Means

Hearing on Fiscal Year 1990 Budget Issues Relating To Graduate Medical Education And Its Support Under The Medicare Program

April 11, 1989

Today the Subcommittee continues its series of hearings on fiscal year 1990 budget issues with an examination of payments in support of graduate medical education.

For too long the discussion on graduate medical education in the Committee has tended to focus on the narrow set of topics surrounding the methodologies used to reimburse teaching hospitals for the costs of teaching. I would submit to you that with expenditures for Medicare's indirect teaching adjustment scheduled to reach $2.0 billion this year while direct medical education will consume $1.5 billion, it is time that we asked what are we buying.

Today's hearing will focus on those larger questions regarding graduate medical education. We will hear from witnesses prepared to discuss whether we are training the right number of physicians and whether we are training the right types.

We appear to have a health care delivery system characterized by a surplus overall in physicians and a shortage of primary care practitioners. At the same time many areas of our country, particularly inner city and rural communities cannot attract sufficient physician manpower.

The question we need to ask first is what role can the nation's graduate medical education programs play in resolving these issues. Second, we should ask what role can Medicare's reimbursement of education play in bringing about desired changes in graduate medical education.

In the past our discussion has particularly focussed on the narrow question of what is the appropriate percentage adjustment needed in each DRG payment to reimburse appropriately for the costs of teaching. We have allowed ourselves to become bogged down in the intricacies of regression analysis without understanding what our goals are.

The Administration has taken this approach in its budget recommendations on the indirect medical education adjustment this year.

We, on the other hand, have to take into account the fact that most of our major teaching hospitals are also the inner city hospitals which provide the largest share of the charity care provided to our poorest citizens. Substantial reductions in these payments may seriously weaken the safety net hospitals on which our present system relies.

At the same time hospitals are not created with an inalienable right to create and maintain teaching programs and to receive extra reimbursement as a result. If there are too many programs, or they are not training the right types of doctors, then it is my view that the Medicare program has the right to take those issues into account in its support of graduate medical education.

Public programs must support clearly identified public purposes, and that test needs to be applied to Medicare's support of teaching programs.

I look forward to the views of our witnesses on these and other issues related to graduate medical education.

Chairman STARK. Our first witness is Dr. Phil Lee, director of the Institute for Health Policy Studies at the University of California and, coincidentally, he is chairman of the Physician Payment Review Commission, a commission whose charge this year in this Congress is large. In addition to looking at the overall issue of compensation, the demand side, I guess, of the equation here, he is also charged with pushing on the supply side of the equation.

And it's with our usual great good anticipation that we look forward to your testimony, and I am sure that you and other witnesses today have prepared testimony which will appear in the record in its entirety. We would encourage the witnesses to summarize or to elaborate or expand on their testimony in any way they are comfortable.

Go ahead, Phil.

STATEMENT OF PHILIP R. LEE, M.D., CHAIRMAN OF THE PHYSICIAN PAYMENT REVIEW COMMISSION AND DIRECTOR, INSTITUTE FOR HEALTH POLICY STUDIES, UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

Dr. LEE. Thanks, Mr. Chairman.

I will summarize my testimony, and I should say that I agree with your overall assessment of the situation—that there is an oversupply of many specialists and subspecialists, and probably an undersupply of primary care physicians.

I want to focus today on some broad manpower issues and not just on the budgetary issues or the formula that this committee looks at to decide how much money to put into the direct and indirect costs of graduate medical education.

The first point I want to make is that physician supply has a direct effect on medical care expenditures. It's been estimated that, for each physician, about $500,000 per year is generated in expenditures. Physician net income, before taxes but after expenses, in 1986 was $119,500. Practice costs of self-employed physicians in 1986 were $118,400 per physician. That adds up to $238,000. It doesn't take a large stretch of the imagination to see how $500,000 per physician might be generated annually when you think of the impact of physician decisions on hospitalization, prescription drug use, and nursing home use.

While expenditures for medical care have gone up rapidly, physician supply has also been increasing very rapidly. In 1960, the United States had 247,000 physicians; in 1970, 326,000. That was 156 physicians per 100,000 population.

In my testimony, you will see the details of those current projections by the Bureau of Health Professions in the Health Resources and Services Administration of the Public Health Service, extending up to 708,000 physicians, or 264 per 100,000 population by the year 2000. And if you consider that each one of those physicians may account for $500,000 in medical care expenditures, you've got a problem on your hands.

In view of the substantial increases in physician supply over the past 20 years—for example, an increase of about 160,000 between 1975 and 1985—we have to ask, how much is enough? When is the supply going to equal the demand?

George Bernard Shaw had the answer. He said, "make up your mind how many doctors the community needs to keep it well. Do not register more or less than this number."

Nobody seems to be able to agree, however, on the number. GMENAC projected an oversupply by 1990 of 69,750 and, by the year 2000, an oversupply of 144,000, with most specialties and subspecialties in oversupply and, in many of them, twice as many as needed.

Jacobsen & Rimm took a somewhat different view. They did some reanalysis of the GMENAC data, and they projected a surplus of 39,000 physicians by the year 2000. If stringent policies were applied to foreign medical graduates, or graduates of foreign medical schools, including U.S. FMG's, they projected a possible undersupply of 6,000 positions by the year 2000.

In 1988, the Bureau of Health Professions projected a surplus of 26,500 physicians in the year 1990, and almost 72,000 in the year 2000.

Another view is offered by Schwartz, Sloan & Mendelson who projected that there would be little or no surplus in the year 2000.

The council on graduate medical education, and you'll hear from them later this morning, has concluded that there is or will soon be an aggregate oversupply. But they said, because of the uncertainties, that the Federal Government should not attempt to influence manpower supply in the aggregate. It did recommend continued efforts to correct geographic maldistribution and increase minority representation. And specifically on the issue before you, the council places the highest priority on reimbursement of residency training stipends and fringe benefit costs, training in those primary care specialties which are in short supply, training in preventive medicine and geriatrics, support for quality GME programs in underserved communities, and support for training of minorities.

The problem with all these predictions has been pointed out by Schwartz and his colleagues who noted that the problem really rests on the assumptions on which the projections are based. They've estimated a range of projected figures—from a surplus of 17,000 to a shortage of 83,000 physicians, depending on assumptions.

I think many of us feel that the assumptions that Schwartz and his colleagues used with respect to demand were on the very high side. And that's the reason they concluded that there would be little or no surplus of physicians by the year 2000.

On geographic distribution you could say the news is somewhat better. Virtually all of the U.S. population now lives within 25 miles of a physician. There has been significant improvement in the physician supply in counties that previously had no physician. There has also been improvement in those counties that had some physicians, but because of the increased numbers of specialists there is still a need for primary care physicians. In summary, the distribution geographically certainly has been improved, but there are still significant problems.

One of those problems relates to the lack of reimbursement and the lack of financing for the care of millions of Americans. We saw dramatic differences in the Physician Payment Review Commission's survey of Medicare beneficiaries, where we found that less than half of 1 percent were denied access to care for financial reasons. However, that is not true for the rest of the population, particularly for the poor and the working poor who are uninsured.

Specialty distribution represents one of the most serious problems that this committee faces, that the Department of Health and Human Services faces, and that the medical schools and hospitals involved in teaching face.

In my testimony I've outlined the projections with respect to projected increases and surpluses. The predictions regarding specialties are particularly significant. Between 1986 and the year 2000, all physicians are expected to increase by about 28 percent, and general and family practitioners by only 14.5 percent. In contrast, medical cardiovascular specialists are projected to increase by 62 percent, gastroenterologists 74 percent, pulmonary specialists 67 percent, anesthesiologists almost 44 percent, diagnostic radiologists almost 60 percent, and therapeutic radiologists 40 percent.

It's interesting to note that two surgical specialties have reached a steady state: In general surgery the projected increase is only 4.6 percent, and in thoracic and cardiac surgery only 0.4 percent. Cardiac surgeons explain that their approach has been to have rigorous evaluation of their graduate training programs and trim out those programs that they find do not provide outstanding training. That is certainly one approach to the problem.

In some specialty areas where there certainly are needs, the supply is, in fact, expected to decline. For example, it's projected that public health specialists will decline by almost 34 percent.

The various figures on the projected supply of specialists indicate that there is still dispute about whether there are too many or not enough. Schwartz and his colleagues have projected that there will not be an oversupply, but most everyone else has projected that there's likely to be an oversupply, particularly in the procedure-based medical subspecialties and a number of the surgical subspecialties.

In considering the question of balance of primary care physicians and medical subspecialists, surgical specialists, other specialists, it is useful to note what the ratios are in other countries. In the United Kingdom, over 70 percent of physicians are general practitioners. In Canada, Belgium, and West Germany, at least 50 percent of the physicians are generalists, in the Netherlands 38 percent, and in the United States between 25 and 30 percent.

In every country that has a substantially higher percentage of generalists than in the United States, and that has universal health insurance, medical care expenditures, per capita and as a percentage GNP, are substantially below those in the United States.

Based on conventional measures of health status, all of these countries are doing at least as well, if not better, than the United States. But where does this lead us and what kind of issues should the committee address?

First of all, current Medicare payments simply support the status quo. There have been dramatic changes in medical care just in the last decade—a declining number of hospital admissions, shorter length of stay, a higher proportion of surgical patients, an increasing proportion of admissions for invasive procedures, increasing use of intensive care, especially at the of life, and a shift in the locus of critical diagnostic and therapeutic decisions out of the hospital. Because of these changes, graduate medical education must undergo major reforms if it is to meet the needs of the population in the future. Increasingly, training for primary care physicians must shift from the hospital inpatient to the ambulatory setting. And the costs of this training must be covered.

Congress clearly has a number of options. One is to do nothing; another is to look at the question of aggregate physician supply and the question of geographic and specialty distribution.

This committee certainly has paid a great deal of attention to the geographic maldistribution problem, and has put that item on the agenda of the Physician Payment Review Commission. A number of the Commission's recommendations will help to deal with the geographic maldistribution problem. They will not, however, deal with the problem of producing too many subspecialists.

I believe that Federal policies can and should influence both the number of residents trained, at least those trained with Medicare subsidies, and the mix of medical, surgical and other specialties trained.

I do not believe that the Federal Government should subsidize the training of subspecialists where there is already an oversupply or there is likely to be one in the very near future. This, of course, is a personal view, and there are other viewpoints and analyses you will wish to consider.

I think you might wish to request the Prospective Payment Assessment Commission, or the Council on Graduate Medical Education, or the Physician Payment Review Commission to review some of these issues for you. You may also wish to request the Institute of Medicine to examine the issues The IOM currently has a committee on the financing of ambulatory care education that might be able to provide informed judgment on these issues.

Thank you very much, Mr. Chairman.

[The statement of Dr. Lee follows:]

STATEMENT OF PHILIP R. LEE, M.D., CHAIRMAN, PHYSICIAN PAYMENT REVIEW COMMISSION

Mr. Chairman, I am pleased to respond to the Subcommittee's request to testify on budget issues relating to graduate medical education and its support under the Medicare program. I have had a longstanding interest in health manpower policy, including the financing of graduate medical education. This has also been of interest to members of the Physician Payment Review Commission, but the Commission has not explicitly addressed the issues of graduate medical education or physician supply and distribution.

The Commission has examined and presented to the Subcommittee data regarding the growth in expenditures for physicians' services, particularly the growth in Medicare Part B expenditures, and I will not reiterate those today.

It is my intention to focus on some broad health manpower policy issues, specifically those related to physician supply, specialty distribution and geographic distribution, and how federal policies affect, or do not affect, these.

Physician supply in the aggregate is of vital importance to assure the availability of necessary medical care. Even when the aggregate supply is adequate, maldistribution of physicians, by specialty or by geographic area, can affect access, cost, and quality of care. Equally important are adequate financing and appropriate levels of reimbursement for services.

Physician Supply

Physician supply has a direct effect on medical care expenditures. It has been estimated that each physician generates about $500,000 in expenditures annually. Physician net nominal income before taxes, but after expenses, in 1986 was $119,500 (Figure 1). Practice costs of self-employed physicians in 1986 were $118,400 per physician. Thus, the total of medical care expenditures per physician in 1986 was $238,000. Add to that the physician influence on expenditures and the $500,000 estimate seems quite reasonable.

While expenditures were increasing rapidly for medical care, physician supply was also increasing--from 247,300 in 1960, to 326,200 in 1970, to 384,500 in 1975, to 457,500 in 1980, to 544,800 in 1986. This dramatic increase is also shown in the physician-to-population ratio--from 156 physicians/100,000 population in 1970, to 197/100,000 in 1980, to 225/100,000 in 1986 (Table 1).

Physician supply is projected to increase to 597,000 in 1990, 708,600 in 2000 and 820,800 in 2020. The physician-to-population ratios will be 239/100,000 in 1990, 264/100,000 in 2000, and 277/100,000 in 2020 (Table 2).

It is hard to ignore the fact that a relationship exists between the continued, rapid increase in medical care expenditures and this rapid increase in physician supply. Keep in mind that physician incomes have doubled in nominal terms since 1977 and have been almost steady in terms of real dollars since 1975 (Figure 1). Between 1975 and 1986 physician supply increased by more than 160,000 physicians--from 384,500 to 544,800--but physicians' incomes did not decline. This 160,000 increase represented approximately one-third of all physicians in 1986. At a minimum, they accounted for over $30 billion in direct medical care expenditures in 1986.

It is not surprising that the mean number of visits per physician declined 15 percent from 1975 to 1985. Between 1982 and 1985, all physicians' fees increased 20 percent, on average, but net income rose only 14 percent because of increased practice costs, including professional liability, and a decline in the number of patient visits per physician.

Looking ahead to an additional 164,000 physicians by the year 2000, one can predict a substantial increase in expenditures for physicians' services.

In view of these substantial increases in physician supply in the past 20 years, it is reasonable to ask, when will supply equal demand? When will it equal need? How do you measure demand or need? How can policymakers and the medical profession decide on the correct number of physicians?

George Bernard Shaw had the answer:

> Make up your mind how many doctors the community needs to keep it well. Do not register more or less than this number. (Preface to The Doctor's Dilemma)

In recent years a number of studies have been conducted to estimate physician supply and demand. Physician supply is easy to measure. It is a function of production, productivity, and retirement. Measuring demand is quite another matter.

The Graduate Medical Education National Advisory Committee (GMENAC) was established in 1976 to consider issues related to graduate medical education, including the future requirements for physicians by specialty. In 1980, GMENAC projected an oversupply of 69,750 physicians by the year 1990 and an oversupply of 144,700 in the year 2000.

It has long been known that staff or group practice model health maintenance organizations (HMOs) require fewer physicians per capita (115/100,000) than fee-for-service practices (197/100,000 in 1980). In 1986, Steinwachs and associates raised questions about the GMENAC projections, based on their analysis of the staffing patterns in large HMOs. They estimated that 20 percent fewer primary care physicians for children and 50 percent fewer for adults will be needed to meet national primary care needs in 1990 than projected by GMENAC (NEJM 314:217-227, Jan. 23, 1986).

In 1987, Jacobsen and Rimm reevaluated available data on physician supply and demand. They found that some of the assumptions by GMENAC concerning physician productivity, gender compositions by practitioners, and enrollment of medical schools did not reflect changes that had occurred. They began with the GMENAC base projection of 642,950 physicians in the year 2000. Based on a series of adjustments, reflecting the changes in the number of U.S. medical graduates and the smaller number of foreign medical graduates (FMGs) entering practice, they reduced the projected number by 33,050. They adjusted for a larger number of women in practice and for changes in physician productivity, which, combined, reduced the number to a total of 537,000, with need projected to be 498,000. Thus, they projected a surplus of 39,000 physicians in the year 2000. If the number of FMGs was dramatically reduced, as recommended by GMENAC, they projected a possible shortage of 6000 physicians in the year 2000 (Jacobsen and Rimm, Health Affairs 6:48-56, Summer 1987).

In 1988, the Bureau of Health Professions/Health Resources and Services Administration/U.S. Public Health Service projected a surplus of 26,500 physicians in the year 1990 and 71,586 in the year 2000. In 1990, active supply was projected to be 597,040 with requirements equal to 570,500. In the year 2000 supply was projected to be 708,596 and requirements 637,000 (Table 3).

There is not universal agreement with the predictions by GMENAC or the Bureau of Health Professions.

In 1988, Schwartz, Sloan and Mendelson projected little or no physician surplus by the year 2000. The assumptions on which Schwartz and his colleagues based their predictions were quite different from those used by the Bureau of Health Professions and GMENAC. They predicted that the equivalent of 112,000 physicians would be involved in research, teaching, administration, and other nonclinical activities. They also projected an increased demand for physicians as a result of technological innovation and other factors that far exceeded predictions by others (NEJM 318:892-897, April 7, 1988).

To bring us up to date on the matter of projections, the Council on Graduate Medical Education/U.S. Department of Health and Human Services reported in July 1988 to the Secretary and to key committees of Congress its conclusions and recommendations. They concluded that there is now or soon will be an aggregate oversupply of physicians in the United States. However, because of the uncertainties, they advised that the federal government should not attempt to influence physician manpower supply in the aggregate. They did recommend continued efforts to correct geographic maldistribution and increased minority representation in medicine. While noting an undersupply of certain primary care physicians, they did not recommend federal policies to attempt to deal with this problem. The Council also recommended continued Medicare funding for graduate medical education. Specifically,

> The Council places the highest priority on reimbursement of residency training stipends and fringe benefit costs, training in those primary care specialties which are in short supply, training in preventive medicine and geriatrics, support for quality GME programs in underserved communities, and support for training of minorities. If reductions are made in reimbursement for the direct cost of GME, these areas should be sheltered from impact. (Council on Graduate Medical Education, July 1988, pp. xxiii-xxiv)

The problem with all these predictions is the assumption on which they are based. The problem was described by Schwartz and his colleagues:

> . . . If technology and other factors cause demand to grow by 50 percent or more than we have assumed, we can anticipate a shortage of 60,000 physicians. If, on the other hand, demand should rise only half as much as we have assumed (perhaps because of rationing of services), we could face a small surplus, but one not likely to exceed 40,000 physicians. If, as seems increasingly likely, competitive medical plans take over only about 25 percent of the market by the year 2000, the situation looks rather different. Under such conditions, we project a shortage of 83,000 physicians to a surplus of 17,000 depending on whether the growth in demand is 50 percent more or less than we have estimated. (Schwartz et al., NEJM 318:895-896, April 7, 1988)

Pay your money and take your choice. A surplus of 71,586 physicians in the year 2000 or a shortage of 83,000 physicians. On the matter of aggregate numbers, I agree with Dr. Jeffrey Harris of MIT who proposes a policy of moderation. He has observed:

> Whatever course is taken, the proposition that there are too many doctors should continually receive careful scrutiny, and not be accepted as conventional wisdom. Maybe the health care sector cannot absorb 17,000 new medical graduates each year. Maybe it can. (Health Affairs 5:73-83, Winter 1986)

Geographic Distribution
The problem is not numbers alone. This Committee has long been concerned about access to medical care for Medicare and Medicaid beneficiaries. Here, the increase in physician supply seems to provide some good news. Virtually all of the U.S. population now lives within 25 miles of a physician. In 1975, 162 counties were without a primary care physician; in 1985 there were only 130 counties without a primary care physician. In 1985, general practitioners or family physicians practiced in all but 188 counties in the United States. Pediatricians practiced in all but 1613 counties in 1985, an increase of 350 counties in a decade, and internists practiced in all but 1156 counties in 1985, an increase of almost 500 counties in a decade. In 1986, however, there were still 126 counties in the U.S. without primary care physicians. As of June 1988, the Secretary of Health and Human Services had officially designated 1914 primary care health manpower shortage areas. About 13 million persons (or 5 percent of the U.S. resident population) remain underserved in the primary care health manpower shortage areas.

Perhaps a better reflection of the greater potential availability of physicians is the physician-to-population ratio. While the population increased by 12 percent between 1975 and 1985, the number of patient care physicians increased by 50 percent, and the number per 100,000 population increased by 34 percent (from 134 to 179/100,000). In counties with the lowest level of services (rural, low-income, health manpower shortage area) the growth rate in physicians per capita was the same as the national average. For primary care, the increase was greater in rural counties, but substantial disparities remain.

Physician-to-population ratios are far lower in nonmetropolitan areas than in metropolitan areas. The range is 303/100,000 in metropolitan areas of 5 million or more and 51.3 in areas of less than 10,000 population. The national average is 203/100,000. For office-based physicians the differences are not so great, ranging from 178/100,000 to 46/100,000. For general practitioners/family physicians the ratio is higher in rural areas (32/100,000) than in large metropolitan areas (24.5/100,000). The national average is 26.8/100,000.

The physician-to-population ratios are highest in several northeast states, Florida, California, Arizona, Colorado, Minnesota, and Illinois. The physician-to-population ratios are lowest in the upper midwest and upper Rocky Mountain areas (Idaho, Montana, Wyoming, North and South Dakota, Nebraska, and Iowa), the south and southwest, and in Indiana, Tennessee, and West Virginia. Costs per capita tend to be higher where physicians are concentrated.

Although the supply of physicians has increased substantially and there is an improvement in the supply of physicians in nonmetropolitan areas, millions of Americans still experience difficulty in obtaining the care they need. In a survey conducted for the Robert Wood Johnson Foundation, it was found that 38.8 million Americans reported difficulty in obtaining needed care. For 19 million the problem was largely financial. The report concluded that between 1982 and 1986 access to medical care deteriorated among the poor, minorities, and the uninsured, especially for those in only fair or poor health. In contrast, the Physician Payment Review Commission's survey of Medicare beneficiaries found that less than one-half of one percent of respondents reported problems in access to care because of financial reasons.

Specialty Distribution
The problem is not just numbers and geographic distribution, but specialty distribution as well. In the Sixth Report to the President and the Congress on the Status of Health Personnel in

the United States (June 1988), the Department of Health and Human Services projected increases in nearly all specialties between 1986 and 2000. The percent change between 1986 and 2000 for all physicians was an increase of 27.9 percent. For general and family practice an increase of only 14.5 percent was projected. In contrast, medical cardiovascular specialists were projected to increase by 62.2 percent, gastroenterology by 74.6 percent, pulmonary disease by 67.6 percent, and other internal medicine subspecialists by 71.8 percent.

Surgical specialists are projected to increase by 20.8 percent, general surgery is projected to increase by only 4.6 percent, and thoracic surgery by 0.4 percent. By contrast, orthopedic surgery is projected to increase by 30.5 percent, plastic surgery by 54.2 percent, and obstetrics and gynecology by 29.6 percent.

Other specialties of particular interest that are projected to increase are: anesthesiology (43.9 percent), diagnostic radiology (59.6 percent), therapeutic radiology (38.9 percent), and pathology (11.4 percent).

Specialties that will decline include: public health (-33.8 percent), pediatric allergy (-21.4 percent), occupational medicine (-17 percent), and allergy (-8.5 percent).

It was the view of GMENAC that most of the medical subspecialties and the surgical specialties would be in oversupply by 1990 and 2000. Indeed, GMENAC estimated that by 1990 the United States would have nearly twice as many physicians in most subspecialties as will be required to meet the need for their services. Dr. William Schwartz, Professor of Medicine at Tufts University, and three colleagues from RAND (Williams, Newhouse, Witsberger) took quite a different view of the supply of medical subspecialists. Noting that, as of 1983, 10 percent to 40 percent of cities with a population of 200,000 to 500,000 lacked a board-certified physician in one or more of the medical subspecialties and many cities of 50,000 to 200,000 lacked medical subspecialists, they concluded that a shortage of medical subspecialists existed in 1983. Even with the projected growth in the supply of medical specialists between 1983 and 2000, they projected that there would still be shortages in some subspecialties in 1990 and in 2000. By the year 2000, they projected that virtually all communities with a population over 50,000, as well as some smaller cities, would have gastroenterologists and oncologists. Cardiologists would be present in nearly all towns with populations greater than a few thousand people. They doubted that the demand in those small towns would be sufficient for the cardiologists to maintain their skills. They believe that increased demand due to population growth, the aging of the population, technology, and increased income will require the increased number of medical subspecialists projected.

In considering the question of the balance of primary care physicians and medical subspecialists, surgical specialists, and other specialists, it is useful to note that in the United Kingdom over 70 percent of the physicians are general practitioners. In Canada, Belgium, and West Germany at least 50 percent of the physicians are generalists; in the Netherlands 38 percent are generalists; and in the United States between 25 and 30 percent are generalists.

Canada might be the most useful comparison, because physicians practice much as physicians do in the United States, largely on a fee-for-service basis. In 1985 Canada had 173 physicians/100,000 population (approximating the U.S. ratio in 1975) and the U.S. had 213 physicians per 100,000 population. Canada had 111 primary care physicians per 100,000 and 89 general and family practitioners per 100,000, while the U.S. had only 92/100,000 and

28/100,000, respectively. For specialists, however, the U.S. supply far exceeded that in Canada (Clare et al., Health Affairs 6:90-103, Winter 1983).

In terms of physician-to-population ratio, only Belgium among European countries is as high as the United States. In 1980 the U.S. had 326 physicians per 100,000, Belgium had 340/100,000, the Federal Republic of Germany 243/100,000, and the United Kingdom only 171/100,000 (approximating the U.S. ratio a decade earlier). Except for the United Kingdom, all Western European countries experienced a rapid increase in physician supply during the 1980s.

In every country with a substantially higher percentage of generalists than the United States, medical care expenditures per capita and as a percentage of GNP are substantially below those in the United States. Based on conventional measures of health status, all of these countries are doing better than the United States.

Medicare Subsidy for Graduate Medical Education

Where does all this lead us? How does it relate to the Medicare payments to teaching hospitals for the direct and indirect costs of medical education?

Current Medicare payments simply support the status quo. There have been dramatic changes in health care in the past decade--a declining number of hospital admissions; shorter length of stay; a higher proportion of surgical patients; an increasing proportion of admissions for invasive procedures; increasing use of intensive care, especially at the end of life; and a shift in the locus of critical diagnostic and therapeutic decisions out of the hospital. Because of these changes, graduate medical education must undergo major reforms if it is to meet the needs of the population in the decades ahead. Increasingly, training for primary care physicians must shift from the hospital inpatient setting to the ambulatory care setting. However, because of the costs entailed, training in ambulatory care settings can take place only if the costs can be adequately covered--as the costs of inpatient training are covered--through current third-party payments.

The Congress has a number of options to consider if it wishes to deal with the issues of physician supply and distribution, as they relate to the costs of medical care. You might adopt policies to limit overall supply, including reducing the number of places in U.S. medical schools or reducing the supply of FMGs. Congress might establish policies to alter specialty distribution, particularly through changes in Medicare payments for direct medical education costs. Congress could, as the Physician Payment Review Commission has recommended, change relative payments for services and procedures. Also, it could alter geographic distribution by subsidizing practices in underserved areas or change geographic patterns of payments, as the Commission has recommended.

Recommendations

I believe that federal policies can and should influence both the number of residents trained--at least those trained with Medicare subsidies--and the mix of medical, surgical, and other specialists trained. It appears that some specialties, such as general surgery and thoracic surgery, have already taken corrective action to relate the supply of qualified surgeons to the need for their services. This does not appear to be the case for medical subspecialties, particularly those dependent on invasive procedures.

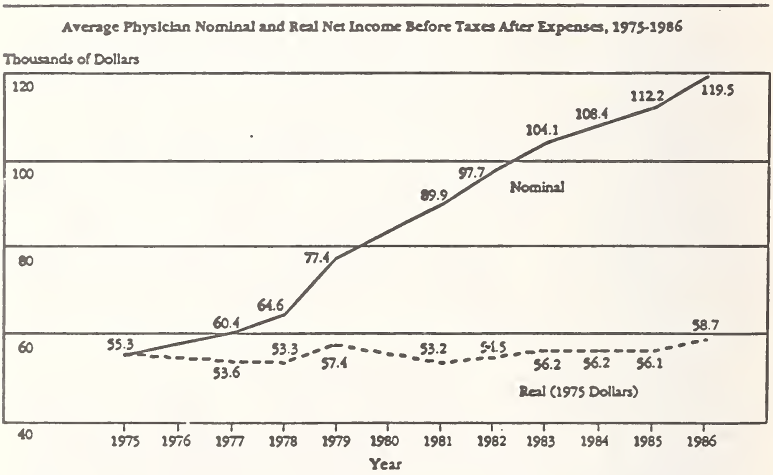
I do not believe that the federal government should subsidize the training of subspecialists when there is already an oversupply or there is likely to be one in the very near future. This, however, is a personal view and you might be better served by a more thorough analysis.

The Congress may wish to request that the Prospective Payment Assessment Commission, the Council on Graduate Medical Education, or the Physician Payment Review Commission review this matter for you. You may also wish to request that the Institute of Medicine (IOM) examine the issues. The IOM currently has a committee on the financing of ambulatory care education that might be able to provide informed judgment on the matter.

I appreciate this opportunity to testify and will be pleased to respond to any questions.

Figure 1

Trends, Variations and the Distribution of Physician Earnings
by Martin L. Gonzalez



SOURCE: AMA Center for Health Policy: Socio-Economic Characteristics of Medical Practice, 1987, Chicago, AMA, 1987, p. 6.

Table 1

ESTIMATED ACTIVE SUPPLY OF SELECTED HEALTH PERSONNEL AND PRACTITIONER-TO-POPULATION RATIOS, 1970, 1975, 1980 AND 1986

	Estimated Active Supply				Percent Change		
Health Occupation	1970	1975	1980	1986	1970-1986	1975-1986	1980-1986
Physicians	326,200	384,500	457,500	544,800	67.0	41.7	19.1
Allopathic (MD)	314,200	370,400	440,400	522,000	66.1	40.9	18.5
Osteopathic (DO)	12,000	14,000	17,100	22,800	90.0	62.9	33.3
Podiatrists	7,100	7,300	8,900	11,000	54.9	50.7	23.6
Dentists	102,200	112,000	126,200	143,000	39.9	27.7	13.3
Optometrists	18,400	19,900	22,000	24,300	32.1	22.1	10.5
Pharmacists	113,700	122,800	143,800	161,500	42.0	31.5	12.3
Veterinarians	25,900	31,100	36,500	43,500	68.0	39.9	20.8
Registered Nurses	750,000	961,000	1,272,900	1,592,600	112.3	65.7	25.1
			Practitioners Per 100,000 Population				
Physicians	156.0	174.4	197.0	224.9	44.2	29.0	14.2
Allopathic (MD)	150.0	167.9	189.5	215.5	43.7	28.4	13.7
Osteopathic (DO)	6.0	6.5	7.5	9.4	56.7	44.6	25.3
Podiatrists	3.5	3.4	4.0	4.5	28.6	32.4	12.5
Dentists	49.5	51.6	55.1	58.9	19.0	14.1	6.7
Optometrists	8.9	9.2	9.6	10.1	13.5	9.8	5.2
Pharmacists	55.1	56.6	62.8	67.1	23.3	18.6	6.8
Veterinarians	12.5	14.3	15.9	18.4	44.8	26.6	14.6
Registered Nurses	366	449	560	661	80.6	47.2	18.0

SOURCE: For sources of data see the appropriate table within the individual chapters for the respective occupations

Table 2

ACTIVE SUPPLY OF SELECTED HEALTH PERSONNEL, ESTIMATED 1986 AND PROJECTED 1990-2020

Health Occupation	Active Supply				Percent Change	
	1986	1990	2000	2020	1986-2000	1986-2020
Physicians	544,800	597,000	708,600	820,800	30.1	50.7
Allopathic (MD)	522,000	569,200	667,700	757,600	27.9	45.1
Osteopathic (DO)	22,800	27,800	41,000	63,200	79.8	177.2
Podiatrists	11,000	12,700	17,100	24,100	55.5	119.1
Dentists	143,000	150,300	156,300	145,800	9.3	2.0
Optometrists	24,300	25,600	30,100	35,700	23.9	46.9
Pharmacists	161,500	171,900	198,600	233,700	23.0	47.7
Veterinarians	43,500	50,100	64,200	81,300	47.6	86.9
Registered Nurses	1,602,400	1,842,000	2,145,100	2,142,500	33.9	33.7
	Practitioners Per 100,000 Population					
Physicians	224.9	239.1	264.4	276.7	17.6	23.0
Allopathic	215.5	228.0	249.2	255.4	15.6	18.5
Osteopathic	9.4	11.2	15.3	21.3	62.8	126.6
Podiatrists	4.5	5.1	6.4	8.1	42.2	80.0
Dentists	58.9	59.9	58.3	49.2	-1.0	-16.5
Optometrists	10.1	10.3	11.2	12.0	10.9	18.8
Pharmacists	67.1	68.9	74.1	78.8	10.4	17.4
Veterinarians	18.1	20.1	24.0	27.4	32.6	51.4
Registered Nurses	667	739	802	724	20.2	8.5

SOURCE: For sources of data see the appropriate table within the individual chapters for the respective occupations

Table 3

SUPPLY/REQUIREMENTS PROJECTIONS

Discipline	Year	ACTIVE SUPPLY	REQUIREMENTS	+ Surplus or - Shortage	Ratio per 100,000 pop	Comments
PHYSICIANS	1970	326,000	INA		155	75% or +245,154
(MD's & DO's)	1980	457,500	INA		197	increase in
	1988	571,154	INA		233	physicians from
	1990 est	597,040	570,500	+26,540	239	1970 to 1988
	1995 est	656,200	INA		253	
	2000 est	708,596	637,000	+71,596	264	
DENTISTS	1970	102,200	INA		50	44% or +45,100
	1980	126,240	INA		55	increase in
	1988	147,300	assumed in balance		59	dentists from
	1990 est	150,300			60	1970 to 1988
	1995 est	154,800	INA		60	
	2000 est	156,300	INA		58	
OPTOMETRISTS	1970	18,400	INA		9	35% or +6,500
	1980	22,400	INA		10	increase from
	1988	24,900	assumed in balance		10	1970 to 1988
	1990 est	25,600	25,800		10	
	1995 est	27,700	INA	No surplus	11	
	2000 est	30,100	29,500	or shortage	11	
PODIATRISTS	1970	7,100	INA		3	66% or +4,700
	1980	8,900	INA		4	increase from
	1988	11,800	INA		5	1970 to 1988
	1990 est	12,800	INA	Undetermined	5	
	1995 est	15,100	INA		6	
	2000 est	17,400	INA		6	

Source for all disciplines: Status of HP in U.S., 6th Report.

SUPPLY/REQUIREMENTS PROJECTIONS

Chairman STARK. Thanks, Phil.

Can you quantify what private groups and Medicaid are contributing to the question of graduate medical education?

Dr. LEE. Well, my impression is that the financing of graduate medical education is through two sources, but principally through third-party payment to the hospitals. And all the third-party payers basically share in those costs.

In some instances, such as public universities, some of those costs are subsidized directly.

Chairman STARK. Can third-party payers make a differential in many cases as we do?

Dr. LEE. I don't believe so. But Blue Cross, Blue Shield, the commercials could certainly give you that information.

As there are an increasing number of negotiated contracts with hospitals for so-called preferred provider organizations where they're squeezing down on the payments, the amount of money that can be allocated for residency training is affected, and that is certainly also true in Medicaid programs.

Chairman STARK. Let me try the Stark plan on you.

If you assume for a moment that something like what your commission has suggested as a way to reimburse physicians comes into being, the odds are that we will be cutting checks for most of the physicians in this country, one way or the other.

So what if we just put graduate medical education, even undergraduate medical education or basic medical education, if you will, on a pay as you go basis in terms of the fees that are charged to the student, and give everybody who matriculates the option of taking a Federal grant, however much is needed to cover their medical education, in exchange for which each year they took the grant, each semester, however they determine it, they would agree to some either fixed percentage of a payroll deduction, say an increase in the Social Security deduction on their earnings or a decrease in the Federal reimbursement of a fixed percentage for the rest of their lives, or their earning lives. This would have the effect of those who enter the highest paying specialties, which might very well also have the most expensive training programs, of returning more to us. Those who went into public service or research would arguably earn less and therefore pay back less and, indeed, if we wanted to get into the business of social engineering and providing doctors for rural or underserved areas, we could waive those fees. And the trust fund that this money would come back into would in time become self-funding. In other words, the money that would be paid back by the people who arguably would have higher incomes as a result of the training would put this money back into the trust fund in the form of seed corn, and given us some period of time, we would put that whole program on a pay as you go basis.

Dr. LEE. In the late 1960's, this idea was carefully considered, I believe, by the White House, and then I think by the Bureau of the Budget. It did not subsequently see the light of day, but it was looked at even more broadly than medical education. Should we do this in other fields as well?

One of the problems that arose was that of putting at a disadvantage low-income students who are not used to borrowing that kind of money.

Chairman Stark. It wouldn't be a loan. Don't misunderstand me. It would be a grant. It would be a gift in exchange for which, you know, you would have the scarlet decimal point stamped on your forehead for all time. For instance, if you only went for a year, you would still have an extra half point on your Social Security ticket.

In other words, you want—particularly if you applied it to all colleges which have been under discussion. So basically it is not a loan that you have to pay back in 7 years, or which arguably is a long time——

Dr. Lee. This was the same idea, stretching it out over your professional lifetime. Subspecialists with higher incomes would pay back more money than physicians earning less.

Chairman Stark. You would pay more.

Dr. Lee. Yes. The current funding for undergraduate education is really quite different from that for graduate medical education. I think that we have to differentiate those, although many people suggest, including the former dean at Harvard, that universities should combine undergraduate and graduate training, at least the first 2 years of graduate medical education.

Chairman Stark. My issue is that we've got all kinds of programs that seem to be designed the wrong way. The repayment is at the wrong time in a person's career track, and it may in fact force bad career choices.

Dr. Lee. I think the incentives now are forcing some bad career choices. I think the incentives for the procedure based specialties are such that residents or undergraduate students are choosing those specialties when clearly those are not what the country needs.

And in many other countries, of course, they're simply not provided those choices because those residencies do not exist. They have to go into general practice or family practice, and the proportions are allocated in a much different way than we allocate here.

I'm not sure about this approach because of the—I think our objective is to try to train physicians to meet the country's needs. The problem is we don't quite know what that target should be.

If you individualize these decisions so much, it becomes difficult to find the best answer to financing graduate medical education. I would certainly separate undergraduate from graduate medical education.

Chairman Stark. Thank you.

Mr. Gradison.

Mr. Gradison. Thank you, Mr. Chairman.

Dr. Lee, I wonder if you could help me understand the way in which the direct and indirect graduate education is financed and, in particular, what proportion of the financing comes from Medicare for direct or for indirect. How important is this $2 or $1½ billion, or whatever we're talking about?

Dr. Lee. Well, the direct costs, of course, are those costs associated with the direct payment for the residents.

Mr. Gradison. Yes.

Dr. Lee. And those are funded with Medicare funds, and I'm not sure what the figure is. I think the chairman said it was going to be $2 billion.

Chairman Stark. Yes.

Dr. Lee. The indirect costs relate to patient care in a teaching hospital. When DRG's were instituted, it was not possible to predict what the case mix was going to be. And it was, in part, a case mix adjustment that was passed through because it wasn't possible to say what the case mix was going to be. Nor was it possible to make sure that the DRG's would be sufficiently accurate to reflect the presumably more severe cases with higher costs that were going to be treated in those hospitals.

Thus, the payment for indirect costs could have come simply as part of the DRG payment, if it had been possible to have a more accurate DRG to reflect the true picture in the teaching hospitals.

The direct costs are somewhat easier to calculate. I'm not sure what percentage of the total direct medical education costs are paid by Medicare, but the Bureau of Health Professions, the AAMC, or perhaps HCFA could provide those exact figures for you.

My guess is it would be probably somewhere around 25 or 30 percent because that's close to what the percentage of those patients are in the hospitals, but I'm not sure about that.

Chairman Stark. Mr. Chandler.

Mr. Chandler. Dr. Lee, I'm wondering if you feel there's an optimum number of physicians per 100,000 in the population that is a target goal that we ought to be establishing, and also for the specialties? Is there some way, if we did do that then, that you could derive a policy that would begin to drive those results?

Dr. Lee. Well, I don't have a figure in my head as to what the optimal figure would be. One approach might be to look at the experience of other countries. For example, the exceedingly high physician supply in Israel has meant severe problems with the cost of medical care and with physician dissatisfaction because their incomes are increasingly depressed as there aren't resources to provide them with the kind of income they anticipate. Israel has an immigration policy that permits physicians to come there from all over the world. I think we could look at that experience and say clearly, Israel has gone too far.

When we look at the costs of medical care in the United States, we find that costs are higher than any other country in the world. When we look at overall physician supply, we find that we are similar to many other countries, or slightly higher than some, such as Canada, but the specialty distribution in the United States is very different.

Based on these observations, I think Congress might wish to establish a target range, rather than an exact figure. In addition, Congress should define objectives. The first would be to assure everyone access to care. I think we have enough physicians to do that, even now.

The second would be to assure a high caliber of training for physicians. This would involve rigorous evaluation of the training programs in order to be sure that the graduates are well trained.

Third, you want to make sure that the costs of medical care are not excessive. I think that's the area where we have to look at manpower policy, particularly at specialty distribution and the supply of specialists and ask, do we have too many? Do we have more than we need to provide the services that we anticipate?

GMENAC did that with expert panels. They estimated what the needs were, then they projected physician supply goals based on those needs, and they concluded that there are significant oversupplies in many specialties. Others have disagreed with the GMENAC projections and have made very different assumptions with respect to demand.

Schwartz and the group at RAND have projected a considerably higher demand. They have even said that they don't think there's going to be an oversupply of subspecialists, except perhaps in cardiovascular subspecialties if I remember correctly from their New England Journal article, there are likely to be cardiologists in towns of as few as 2,000 people. Well, we don't need a cardiologist for every 2,000 people in the United States.

Mr. CHANDLER. Right.

Dr. LEE. So, clearly, we'd say that is an oversupply. I think we have to make those kind of informed judgments. I think that this kind of process is how we can estimate target ranges with respect to aggregate supply and then by specialty.

Mr. CHANDLER. Is there anything in terms of Medicare reimbursement, either for the teaching hospital or for patient reimbursement in its general form that can be done to alleviate the geographic maldistribution, because, as you say, there may be a cardiac specialist for a community of 2,000? I think it's more likely that the community of 2,000 wouldn't have a physician at all in many parts of the country, in my State especially.

Dr. LEE. I think the most important thing from a policy point of view is to establish a resource-based relative value scale for physician payments under Medicare, As you know, that recommendation is now before the Congress for consideration.

Mr. CHANDLER. Right.

Dr. LEE. The second step relates to the geographic multiplier. Once you've converted a resource based relative value scale to a fee schedule, then a geographic multiplier is used to take into account the geographic multiplier. In many cases rural areas have higher practice costs than urban areas.

One of the problems is how small a geographic area do you cut out to figure out the geographic multiplier. If you do it for a whole State, physicians in urban areas and even those in some of the higher cost rural areas, won't then get a level of reimbursement to actually reimburse them for their costs.

So one of the things the Commission will be looking at is the carrier areas for a geographic multiplier. I think that's a very important consideration.

Mr. CHANDLER. I agree.

Dr. LEE. As far as the subsidies for teaching hospitals, the main thing there would be to provide adequate subsidy for primary care training in the outpatient setting, which is not being done at the present time. Because inefficiencies occur in patient care when you train physicians in the outpatient setting, there are higher costs. And I believe that Medicare and other third parties are not funding adequately those costs now. This is an area that both the Prospective Payment Assessment Commission and the Physician Payment Review Commission might look at for you.

Mr. CHANDLER. Thank you, Doctor.

Thank you, Mr. Chairman.

Mr. Levin [presiding]. Mr. Moody, I believe you're next.

Mr. Moody. Thank you.

What do we mean by oversupply? You use the term oversupply, but you need an anchor against which to measure. Economists like to think that it's impossible to measure over- or under-supply without any regard to price, that you can't really say it's oversupply.

It seems to me that data bears that out. From 1975 to 1986, according to your paper, the supply of physicians went up about 42 percent. Yet, income remained roughly the same. In fact, it even slightly increased. In any other market good you can think of, if you had that kind of dramatic increase in supply, you would have a corresponding decline in price.

But since the demand curve is nonexistent or very strange, their incomes remained the same, despite the rapid increase in the supply of physician services. Which leads one to think that whatever number of physicians will be out there will be employed, will be busy, will work 8 hours a day or more, maybe 12 hours a day, and they'll have an endless stream of patients to see one way or the other.

So what does it mean to have an oversupply?

Dr. Lee. Well, the medical market doesn't function as a normal market. The fact that we have insurance for most services and the fact that the consumer is not informed as they are with other market goods, means we have an imperfect market in medical care. We can continue to produce physicians but, at some point, we begin to see the problem of saturation in the market.

Mr. Moody. Well, that's my question. How will we know when we're approaching that point since whatever physicians are out there will be busy, will have patients, and will be occupied.

There aren't physicians on unemployment lines. Physicians are not like steelworkers.

Dr. Lee. No. But we're seeing increasing numbers of physicians working shorter hours, particularly in some urban areas where most people feel there is an oversupply. They're working shorter hours and doing multiple different jobs. They are not in office-based practice to the same extent that physicians used to be. More physicians are on salary——

Mr. Moody. But why is that bad? I'm being the devil's advocate a bit here.

Dr. Lee. I'm not saying it's bad. The question is, how much can the country afford? We already pay 3 percent more of our GNP for medical care than any other industrialized countries. We are increasingly noncompetitive internationally. One of the big consumption costs is the cost of medical care.

Mr. Moody. I mean look at the phenomenon of lawyers, another profession. Our society shows that it can absorb an infinite number of lawyers.

Dr. Lee. I'm not sure that we would benefit from that, however. [Laughter.]

Mr. Moody. I mean the number of lawyers can go up to any number you want and they will all be busy. They won't all be in courtrooms practicing law, they'll be advising clients, they'll be administrators, they'll be doing lots of other things.

As you say, doctors will be doing a lot of other things besides seeing patients. Is that bad?

Dr. Lee. I think it's bad because it robs resources that should be spent in other fields, like education. If we put more and more money into medical care, we're going to have less money available for other national priorities. And I think that's the issue, not whether a particular target is the right number or not.

Mr. Moody. Every doctor will be busy doing something worthwhile?

Dr. Lee. Relatively busy, yes.

Mr. Moody. I guess you're saying that those resources can be more effectively used training mathematicians or physicists or something else?

Dr. Lee. Right. Also, with an oversupply we would tend to have more medical care than is probably necessary.

Mr. Moody. But what is necessary? Again there's no anchor on that term either, is there?

Dr. Lee. No. It's hard to define. But the risks increase, I believe, and then again that's an unnecessary expense.

But, to me, it's the aggregate expense, the allocation of resources for medical care. We could go up to 15 percent if we choose to. No other country chooses to do that. I think Japan puts around 6 percent of their GNP into medical care. We're putting 11½ percent in, 0.5 percent more.

Mr. Moody. Well, that's what I'm trying to get at. The oversupply is so easy to knock down because with respect to price you can always argue the supply is adequate or just about right. I've used lawyers as an example.

So unless you want to tie it to what other industrialized countries have chosen to do, and look at the ratio of their physicians per 100,000 people or some other ratio, relative to their health care indices, then I think you've got something that's more solid than the word "oversupply."

Dr. Lee. Plus, I think, the aggregate expenditure. I think that's really the fundamental issue.

Mr. Moody. You could argue that a wealthy society has an income elasticity of demand for health care which exceeds one. So, as the society becomes better off, the demand for health care goes up more than proportionately. That's an argument again you couldn't just knock down. There's nothing wrong with that.

Airplane trips and a lot of other things go up more in proportion with income. So it is not necessarily true that we spend a higher percentage of GNP on medical care than other countries. If we're wealthier, that may be in order. You don't need to eat so much bread and other staples.

Dr. Lee. Right.

Mr. Moody. There's elasticity for certain items like health care that goes up more than proportionately.

The question is, if other countries have comparable levels of income, are spending far less or substantially less than we do on health care, and have equally as good or even better levels of health, then I think you've got something to pin the staple on here.

That's why I'm reacting to the term oversupply and how we get a more objective set of statements out of your paper.

Dr. LEE. Other countries spend between 6 and 8 percent or 9 percent of GNP, and they provide universal coverage. In other words, everybody is covered in Germany, France, Scandinavian countries, Canada, Australia, and they all do it——

Mr. MOODY. Are they healthier because you might have universal coverage? There are some countries that have nominal universal coverage where there are long queues and unhealthy people.

Dr. LEE. The health status of the population, as we measure it by conventional health statistics, in most of those countries is equal or better than in the United States.

Mr. MOODY. I think your paper is enormously valuable and interesting, but I want to just bear down on this question.

Dr. LEE. I like that approach actually.

Mr. MOODY. Thank you.

Mr. LEVIN. Mrs. Johnson.

Mrs. JOHNSON. Thank you.

Doctor, this direct and indirect financing of medical education, the direct payments that the Government makes to the hospitals, at least it's my understanding that this is an offset for the salaries that the hospitals pay residents?

Dr. LEE. That's right.

Mrs. JOHNSON. So that's their base overhead, and it's a way of contributing to that overhead.

The indirect costs, you described as an adjustment for case mix, that's not my understanding of the indirect subsidy.

Dr. LEE. When they set up the DRG's, they were not able to say what the appropriate level of payment should be in the teaching hospitals because patients are often sicker. Severity would have been the right term to use rather than case mix.

Mrs. JOHNSON. Well, is that the level that the Government was using to recognize the case mix issue beyond the DRG issue?

My understanding of the indirect payment provision was that it compensated hospitals for the fact that training residents is costly; that when you have a resident operating with you, you have to operate more slowly because you have to keep explaining to him, this is why you make the incision here instead of there; watch out when you get down to this level not to hit this organ rather than that organ. I mean it is slower.

Dr. LEE. It's costlier, but the DRG payment doesn't account for that.

Mrs. JOHNSON. That's right.

Dr. LEE. Yes.

Mrs. JOHNSON. That's right.

So I think when you say it accommodates for case mix, that's a little confusing.

Dr. LEE. To be more correct, it is for additional costs associated with patient care, not the cost of the doctor. In other words, the direct payment is for the cost of the resident's salary. The indirect is for the higher costs associated with the teaching setting.

Mrs. JOHNSON. That's right.

Dr. LEE. Yes.

Mrs. JOHNSON. That's right. It does take longer to do an operation so maybe you can do fewer operations a day. You have a larger team——

Dr. Lee. They order more lab tests and they order a lot more procedures.

Mrs. Johnson. That's right.

I think that's very important for us to recognize, and there's more waste. Mistakes are made with materials, not necessarily with people. But these costs of training are significant, and I just think we have to be careful to well understand that this is a real cost of doing business. It is every bit as real.

I guess what I'm asking you is do you see it as every bit as real as salaries?

Dr. Lee. Well, I think that the question is, what has been the experience since the DRG's went into effect in 1983? And you need to look at the data on the so-called profit of the hospitals, and particularly the teaching hospitals. And whether the indirect payments have contributed to the accumulation of reserves in the teaching hospitals.

Mrs. Johnson. And is there any data on that?

Dr. Lee. Oh, yes. In some teaching hospitals, it clearly has contributed to the profit margin. In others, such as in New York City, the hospitals are in serious financial condition for a variety of other reasons—the drug epidemic, the HIV epidemic, and other problems.

I think that a number of teaching hospitals have done better than the nonteaching hospitals financially. I don't happen to have the figures, but the data should be available.

Mrs. Johnson. Does the data seem to indicate that the other payments are more in line with costs; that the compensation for indirect costs is generous, whereas other payments within the system like number of Medicaid dependent patients or number of uninsured? In other words, where payments are not——

Dr. Lee. Those can more than compensate. In some of the urban teaching hospitals in low income areas, particularly public hospitals, they are taking care of so many uncompensated care patients and so many Medicaid patients where the reimbursement isn't adequate that they certainly don't show even a break-even; indeed they're in a very, very serious financial situation.

Mrs. Johnson. But you're saying in the hospitals where the relationships between patients and payments is closer, that we're—in a sense, you can look at the adequacy of the uncompensated care payment—I mean the indirect medical education subsidy in a sense in a purer environment. But it does seem to be adequate.

Dr. Lee. Well, I would say that would be my rough estimate, yes.

But the important point is that you have to look at the inequity resulting from a generalized policy that can benefit some hospitals, while other hospitals are still in serious trouble despite the fact that they're doing the kind of work that you want to have done.

Mrs. Johnson. And one of the reasons we're having difficulty looking at this particular component of subsidy of medical education is because the circumstances vary not as a function of that, but as a function of adequacy of compensation for uninsured and so on, other categories.

On to the oversupply issue. It's my understanding that applications to medical schools have steeply declined. I think it wasn't many years ago, when there were 14 or more applications per place. And my understanding is that there are now about two or——

Dr. Lee. Well, the number has declined. But those were total applications. The number of actual applicants perhaps reached a peak in the midseventies. And Dr. Gellhorn may have some accurate figures on these or you could get them from the Bureau of Health Professions.

My guess is it would have been probably around four applicants per place in those days, and now we're down to maybe 1.6 or 1.8. So there has been a decline.

It's interesting that in Canada, there has not been a significant decline in applicants to medical school.

Mrs. Johnson. Does this decline in applicants change the projections of GMENAC?

Dr. Lee. The projections are influenced by several factors.

One, there are many more women in medical school now. And when you project the number of hours that they're likely to practice because they often have two jobs, that is, their practice and raising children and taking care of the home, they will work fewer hours. I think that's been one of the factors considered by people now looking at the GMENAC projections.

Also, there have been more people in research and administration and teaching than GMENAC projected. Because of that factor, other modifications need to be made. In addition, physicians in general are working somewhat shorter hours. Again, that affects those projections.

But you've got both the supply side projections and then the demand, which is the most problematic. Where is the demand and how much demand is there? And that's where the big difference is among those who project an oversupply and those who project either no oversupply or a shortage.

Mrs. Johnson. Then it's a question of whether you define demand as demand, including specialists and generalists, or whether you look at demand from the public policy point of view as primarily generalists.

Dr. Lee. Well, they look at it in both ways. And also it really depends on how much you think income is going to affect future demand and how much you think new technologies will affect demand. Some people project a continuous increase in the new technologies so there will be a continuous and significant increase in demand. Others don't accept those methods of projection. And that's where it's so confusing.

You get these widely different views about whether we have an oversupply or not.

Mr. Levin. Doctor, let me ask you about your testimony in terms of the enigma we face.

Your testimony is impressive and, as usual, provocative. Now, help us with our dilemma.

You know, there's a proposal in the administration's budget to cut the adjustment the teaching hospital factor very substantially. And if we don't find it there, the question is where do we find it? About a billion dollars is involved in that proposal. That's a lot of money.

And I think our dilemma is this, that when you look at the profit margins, it's one way that we will examine the issue, I'm sure, not the only one but one of them, the profit margins for teaching hospitals are somewhat larger than the average. But that's not true for those in major urban centers where it's smaller .

So we are kind of in this trap. And I'm not quite sure what your testimony means for this issue. But give us the benefit of your insights. I guess maybe we've talked about it before. But what do you think the thrust of your testimony means for this issue, if there is any direct impact?

Dr. LEE. Well, let me say that, first of all, with respect to the direct payments for residents, I do not believe that Medicare should pay for the training of medical subspecialists. In other words, if schools are training subspecialists in medicine—let's say cardiology or gastroenterology, I think those should be done after the 3 years of graduate medical education is completed, and those should not be funded by Medicare, because I think we have an oversupply in the subspecialties. I think you need to have information about the distribution of residents and where the money is going. Perhaps it could be provided by AAMC or by AMA or by the Bureau of Health Professions. I think there needs to be increased subsidy for direct payment, because I think the subsidy is inadequate now for primary care training, particularly in the ambulatory setting.

I also think you need more information than has been provided to you about the cost of training those general internists or family physicians in an ambulatory setting. The overhead costs are high. So that I think that's an area that has to be looked at.

With respect to the indirect costs, there I think it's a matter of whether the administration has provided you with adequate information about the hospitals. If you decided to reduce the subsidy for indirect payments you might consider exempting hospitals with high levels of uncompensated care or high levels of uninsured—which is often the same thing—or a high percentage of Medicaid patients so that you don't cripple those hospitals that are already at the margin. Those could be voluntary hospitals or they could be public hospitals. In other words, there could be a carve out for those hospitals.

Let's just take the hospitals in New York City which face extraordinary financial difficulty. You cannot treat the hospitals in New York City the same way you treat the hospitals in Lincoln, NE, or St. Louis, MO, or Nashville, TN, where you do not have a drug epidemic, an AIDS epidemic, or a large number of uninsured individuals.

I believe you have to consider a carve out under any uniform policy that you establish with respect to the indirect subsidies.

Mr. LEVIN. Well, maybe the panelists, and we are going to soon be into the second or the first panel, will address that.

What you're saying is that indirect medical adjustment—that adjustment is a proxy for other factors. And we discussed this yesterday. And I think the subcommittee very much would like to disaggregate, if we can, but there are a couple of questions with that.

One of them is whether we have the data to do that. And, second, whether it's so controversial that we are going to end up, a number of us, proposing something that will encourage what we favor.

I don't think the subcommittee wants to penalize the large teaching hospitals in this country that are now perhaps being compensated for costs that are not directly related to indirect medical education costs, but for other functions that are indispensable.

Dr. LEE. Absolutely right.

Mr. LEVIN. But before we go along that road, I think we want to know that we can traverse it immediately. And I'm not at all sure we can.

So your help, your continuing help is always indispensable. One very quick question.

Dr. LEE. If the Physician Payment Review Commission could be of assistance regarding some specific questions, we would be glad to be of help.

Mr. LEVIN. Well, that's the question. I mean it's very specific.

And there's a proposal for a billion dollar cut, right? And I think there's some controversy about the profit figures, but I think maybe I'm wrong. But the basic thrust of them is accepted.

If you take all teaching institutions, maybe they're above average, but you pull out the ones in the larger centers, they're below it. So, you cannot simply, as the administration suggests, sock it to all teaching institutions without going against the notion of not a kinder and gentler nation, but just a kind and gentle nation.

Dr. LEE. Well, when Dr. Gellhorn testifies, perhaps he can give you some more specifics on New York because to me that epitomizes the problem that you have to address generically.

Mr. LEVIN. Settle in New York, it's right, it's spread throughout this country.

Dr. LEE. All urban areas—Los Angeles, San Francisco—are facing problems but not to the same degree.

Mr. LEVIN. One last quickie.

So much of this material is of interest. Maybe one of the most striking figures is the number of generalists.

Just briefly, from your long experience, why are we so low on that scale? Why does the United States have this high percentage of specialists versus generalists compared to other countries?

Dr. LEE. Well, it may not be more than any other country, but certainly we're very strongly committed to what Victor Fuchs called the technological imperative. We are very much in love with technology. And that's as true in medicine as elsewhere.

I would say the fundamental reason, if there is one, is that beginning in the midforties, we began to support biomedical research in medical schools. That produced, within the schools, a cadre of faculty more interested in biomedical and technological advances than in the broader health care and health manpower issues.

That, probably more than any other factor, differentiates the United States from France, or Germany, or Canada, all of whom have fee-for-service systems. We simply have put much more biomedical research investment in the medical schools to advance the field technologically. That's an area where we like to be ahead of the others.

For this reason, there's an incentive within the academic medical center to specialize and subspecialize. And that's where the residents are training primarily.

The second factor, which is perhaps not equally important, but I think is significant, is that we pay physicians in those subspecialties, and particularly in technologically based specialties, more than they get paid in almost any other country. So we have, on the supply side, a push in that direction, and on the demand side, a pull in that direction.

I think those are the two primary factors for the high level of specialization in the United States. With the resource-based relative value scale we're moving to correct one of those. We have not yet moved on the supply side to correct the other.

Mr. Levin. All right. Thank you.

We are going on to the next panel then, and our chairman has returned.

Pete, we're just ready now for Doctors Gellhorn, Vanselow, and Anderson.

Chairman Stark. Thank you. Thank you, Phil.

Our next panel consists of Dr. Alfred Gellhorn, the director of medical affairs at the New York State Department of Health, and chairman of the New York State Commission on Graduate Medical Education; Dr. Neal Vanselow, chancellor of the Tulane Medical Center, and chairman of the Council on Graduate Medical Education of the Department of Health and Human Services; and Dr. Gerard Anderson, director of the Center for Hospital Finance and Management of the Johns Hopkins Medical Institution.

Your prepared statements, gentlemen, will appear in the record in their entirety, and we would encourage you to supplement or summarize your testimony in any manner you are comfortable.

Dr. Gellhorn.

STATEMENT OF ALFRED GELLHORN, M.D., DIRECTOR OF MEDICAL AFFAIRS, NEW YORK STATE DEPARTMENT OF HEALTH, AND CHAIRMAN, NEW YORK COUNCIL ON GRADUATE MEDICAL EDUCATION

Dr. Gellhorn. Mr. Chairman, members of the committee, I'm delighted to have the privilege of being here, and feel, Mr. Chairman, that your opening statement is a very significant part of my testimony. I really much prefer to enter the debate that has been going on, but will attempt very briefly to summarize my written testimony.

I will attempt to support that Medicare should maintain its subsidy for graduate medical education, but it must be, in my estimation, better used to meet societal needs.

I will break my report into two aspects. One, I would like to use New York as an example, as perhaps a paradigm for the Nation, and emphasize the need for more primary care physicians.

I wish to make an emphasis on the need for greater representation of minorities in graduate medical education, and I wish to discuss the Organization of Graduate Medical Education where new issues require a new look at the Organization of Graduate Medical

Education, including the training in geriatrics. in chronic care medicine, and AIDS.

I also then, in the second part, wish to have the impertinence of making a proposal for what Congress can do to assist, encourage and provide leverage to make graduate medical education more responsive to national needs.

I will suggest that the eligibility for Medicare support of graduate medical education be tied through the development of a State plan that identifies societal needs and directs graduate medical education resources to meet those needs.

New York with Medicare and other sources support, expends $1 billion plus annually in the area of graduate medical education.

The first fact that I would like to bring to your attention or further focus on the primary care issue is again why are we so lacking in primary care physicians, and again Phil Lee addressed this when he pointed out that, after World War II, there was the explosion of biomedical knowledge fueled by Congress in terms of research that was provided. And this led to the rapid increase in the clinical specialties and subspecialties.

At the outset, we had five specialties that were recognized: medicine, obstetrics, gynecology, surgery, psychiatry, and pediatrics. Now there are 23 nationally recognized specialty boards and 80 additional specialty areas that are not nationally recognized. The consequence of this has been that rather than what we had at the outset, approximately 70 percent of physicians who were providing general medical care, and 30 percent who were in specialties, this has now been completely reversed such that we now have 30 percent in the general area, 70 percent in the specialties.

It is, obviously, compounded, as has been indicated, by our reimbursement of physicians' medical care, which has led to this distortion really in terms of the compensation of physicians, depending upon whether they are specialists or generalists. And by generalists, I mean family medicine, general medicine, or primary care internal medicine, and general pediatrics.

One of the consequences of our failure of having an adequate supply of primary care physicians has to do with the growth of the prepaid programs where there is demand for generalists, and that demand is not being met. We are not meeting the needs of our aging population, and we are not meeting the increasing requirements of young and old with chronic illnesses, The expectations of preventive medicine are not being realized. And the management of the new illnesses in our society, the psychosocial problems, are being poorly handled.

So we not only have, in my estimation, a problem with regard to the distribution among the specialties, but we also, have not met the needs in terms of geographic distribution, at least in our State. We have 4 million out of our 17-plus million population that live in medically underserved areas, in poor rural areas, and in the inner cities.

As a result of the failure of providing primary care physicians, we are making a major contribution, inappropriate, too late, ineffective, very expensive, overutilization of hospital emergency rooms and inpatient facilities.

We are providing inadequate primary care in those centers where the AIDS epidemic is significant. We do very poor medical care for the homeless, including children, for the deinstitutionalized, mentally ill, for persons in the drug abuse treatment facilities.

In New York, there has been created a council on graduate medical education, which has made recommendations. And in the area of primary care, it has recommended that a majority of the residency positions be in primary care. It has recommended that the subsidy for graduate medical education should be modified to encourage an increase in primary care residencies, and very significantly, although we constantly talk about graduate medical education being a hospital area, we must increase the training of our physicians for the 21st century in ambulatory care because that's where the major part of the medical care for the future is going to be carried out.

So much for primary care. Again, if I can use another issue which I believe is a national issue, and certainly it is in our State, namely minority representation in graduate medical education.

In our State, we have 24 percent of our population are either black or Hispanic. Only 4 percent of the physicians in the State of New York are minority practitioners. Not only is the absolute number distressingly low, but when we look to the distribution of minorities in the various specialties, we again find striking discrepancies.

For example, in New York, there is one black neurosurgeon and five Hispanic neurosurgeons in the entire State.

I will not dwell on that or on the Organization of Graduate Medical Education. Let me turn finally to a proposal which might remedy some of these problems, not only State by State, and recognizing the differences in the State.

I think that it is inappropriate that graduate medical education should be subsidized as a workshop to acquire knowledge and skills which can be used solely for personal gain, but rather it is to acquire skills and experience to be used for community benefit.

In order that this intent of Congress be realized, broad characteristics of graduate medical education could be expressed in legislation which could include increase in primary care specialties, improvement in the distribution of practitioners to favor underserved populations, increase in minority representation, development of training in ambulatory long-term and home care.

Each State then would be asked to submit its plans for graduate medical education as part of the State health plan, which is required of each State to meet Federal financial participation in the Medicaid Program.

Eligibility and acceptance of the graduate medical education component would not only have an impact on the Medicaid Program but would determine the Medicare reimbursement as well.

Thank you very much. I think if we did this, we would improve the preparation of physicians for the 21st century.

[The statement of Dr. Gellhorn follows:]

TESTIMONY ON GRADUATE MEDICAL EDUCATION

Alfred Gellhorn, M.D.
Director of Medical Affairs
NYS Department of Health

Mr. Chairman and Members of the Committee: My name is Alfred Gellhorn and I am Director of Medical Affairs in the New York State Department of Health and Chairman of the New York State Council on Graduate Medical Education. In my long career in medical education, I have been a Professor of Medicine at Columbia University College of Physicians and Surgeons, Dean of the Medical School at the University of Pennsylvania, first Director of a new medical school at City University in New York, and Visiting Professor after retirement at the University of North Carolina and Harvard School of Public Health all before joining in the New York State Department of Health six years ago. I am delighted to be here.

INTRODUCTION

Prior to 1965, the cost of graduate medical education was borne by hospitals, and the residents received negligible salaries plus room, uniforms and board. With the enactment of Medicare legislation, a fundamental policy and philosophical decision was made. The training of doctors was considered to be a public good which should be supported by tax money.

The growth of graduate medical education since 1965 has been constrained in part by National Residency Review Committees but, more significantly, by the number of medical school graduates to be appointed. This group has included not only graduates from U.S. medical schools, but foreign medical graduates as well. The cost of the public good has grown dramatically -- multibillion dollars through the Medicare program alone to subsidize the cost of graduate medical education. This amount does not include the significant state and federal contribution through the Medicaid program and educational grants, and support from other forms of hospital insurance. We have estimated that in New York State approximately $1 billion of public funds are expended every year to finance the cost of graduate medical education.

No other professional training is funded in this way and to this extent. The expenditure of such funds has been justified because health care, and by implication graduate medical education, is a social good. We as a society have been willing to support graduate medical education in order to ensure that the health care needs of future generations will be met by well-trained physicians.

As medical practice has embraced applications of technological innovations and as the population has aged, the costs of medical care have escalated. With the annual expenditure for health care in excess of eleven percent of the gross national product and with uncertainty regarding the value of certain aspects of medical care, a critical examination of the direction of medical education and medical practice is taking place nationally and in New York. Are the needs of society being appropriately and well met? Is access to medical care equitable, regardless of socioeconomic status? Is the distribution of training in specialized areas of medicine disproportionate to the training of generalists? Is the representation of medical students and residents from various cultural, ethnic and racial groups reflective of the diversity of the population in the nation or the state? These and other issues require a review and possible modification of the justification for the continued subsidy of graduate medical education.

The public subsidy for graduate medical education carries with it a weighty obligation, both for the institutions responsible for physician training and for state and federal officials. We must identify societal needs and ensure that physicians are being trained to meet them. Under those circumstances, the graduate medical education subsidy is indeed a justifiable public tax. And it is and must be effectively used as a powerful instrument for public good.

In my testimony today, I will attempt to demonstrate why the support of graduate medical education should be maintained and how it can be used to meet pressing societal goals and objectives. First, I will describe the needs we have identified in New York State -- including the need to increase the proportion of primary care physicians, to increase minority representation in the medical profession, to improve the organization of graduate medical education, and to train doctors in issues of geriatrics, chronic care medicine and the care of patients with HIV-infection.

Next, I will describe the various possibilities being considered in New York for ensuring that the training of physicians in the state will meet the needs we have identified.

Finally, I will outline a proposal for what the Congress can do to assist and provide encouragement -- and leverage -- for these efforts. I propose that state eligibility for Medicare support of the costs of graduate medical education be tied to the development of a state plan that identifies societal needs and directs graduate medical education resources to meet those needs.

BACKGROUND

World War II medical research paid off impressive dividends in lives of soldiers saved and disease prevented. After the war, Congress, with the enthusiastic support of the electorate, appropriated unprecedented funds for biomedical research, and again, the dividends in terms of the control of infectious diseases with new antibiotics and the prevention of childhood death by viral vaccines justified the expenditures which contributed to an increased average length of life from 66 years in 1950 to 74 years in 1985. Advances in knowledge were obviously not confined to antibiotics and vaccines, but rather encompassed the gamut of biology and medicine. A particularly relevant consequence was the rapid proliferation of medical specialties and subspecialties. The pass-through reimbursement for graduate medical education in the

Medicare legislation, combined with the tremendously favorable reimbursement for high technology diagnostic and therapeutic procedures provided by specialists, transformed the profile of graduate medical education such that 70 percent of the residency training was in specialty areas and only 30 percent in the general or primary care categories.

Medicare and Medicaid had the lofty intent of making access to health care available to all regardless of age or poverty. Clearly, however, a variety of social and economic circumstances have thwarted this objective. Thus, at the present time, some 30-40 million persons in this country are without any form of insurance. The tradition of charity medical care provided by doctors and hospitals, both private and public, became a romantic memory as the availability of funds from public sources has fueled the fee-for-service system. It is now the resident staff that often provides the physician care of the Medicaid and indigent populations who turn to the emergency services, out-patient clinics and when necessary the hospital in-patient beds. In fact, meeting the service needs of hospitals too often takes precedence over education of the resident staff. This, parenthetically, led to requirements in New York for better working conditions and more supervision of residents as a means of improving their educational experience.

Is this valuable service provided by residents an adequate justification of the graduate medical education subsidy. In my opinion, it is not sufficient.

PRIMARY CARE MEDICAL TRAINING

A survey of physicians practicing in New York showed that 80 percent had their graduate medical education in the state. The characteristics of residency training now will, therefore, shape the practice of medicine in succeeding decades.

Over the past decade, there has been a growing national consensus that a mismatch exists between the proportion of primary care doctors needed (about 70 percent) and the proportion in practice (about 30 percent). Indeed, the United States has a smaller percentage of generalists, i.e., family medicine, primary care internal medicine and general pediatric physicians, than any other Western country. The demand for primary care doctors is related to the growth of prepaid managed care, to our aging population and both young and old with chronic illnesses, to the expectation for preventive medicine, and to the management of the new morbidity, the psychosocial problems.

Not only is there a shortage of primary care physicians in New York, but their geographical distribution fails to meet the needs of over 4 million underserved people in rural areas and the inner cities. The shortage and maldistribution results in a multitude of problems for health care delivery in the state and is a major contributor to inappropriate, too late, ineffective, very expensive over-utilization of hospital emergency services and over-crowding of hospital in-patient facilities. This is tremendously exacerbated in New York by inadequate primary care medical services for AIDS patients, for the homeless including children, for the deinstitutionalized mentally ill, and for persons in drug abuse treatment facilities.

New York has a State Council on Graduate Medical Education charged with developing the medical manpower to met the needs of the state. To address the problem of too few primary care physicians, the Council has recommended:

1. A majority of all residency positions should be in primary care specialties.

2. The costs of graduate medical education should be modified to encourage residency programs to increase their percentage of residents in training in the primary care specialties relative to other specialties, and subspecialties and to provide support for primary care training in ambulatory care settings.

3. The current subsidy of family practice training programs should be increased and extended to the other major primary care specialties, general internal medicine (primary care internal medicine) and general pediatrics.

4. Physician Loan Forgiveness programs are available for physicians who train for primary care and then practice in shortage areas of the state. The Council recommends that these be increased from the current 80 at $10,000 per year to more than 100 and a larger annual loan forgiveness. Indebtedness after medical school is a significant disincentive for primary care training and effort to overcome this is critical.

5. An even greater disincentive for primary care practice is that compared with various specialties and subspecialties for which reimbursement is unjustifiably high, primary medical care is poorly reimbursed and for Medicaid-eligible patients is insufficient to sustain the practice. It would serve little purpose to increase primary care graduate medical education and then offer no financially viable future to those physicians who are needed in underserved communities. In New York, 16 separate programs have been developed which significantly augment the Medicaid fee-for-service payments and, it is hoped, will encourage those imbued with the medical tradition of service to meet the social needs of the state.

MINORITIES IN GRADUATE MEDICAL EDUCATION

The exclusion of minorities from medical school and graduate medical education is a well established fact. From 1920 until 1964, only 2 to 3 percent of the total entering medical school classes was black, and the vast majority were at Howard and Meharry. It was not until 1966 that all medical schools were open to black students and, even then, minorities were often admitted only on a token basis.

Minority doctors were also excluded from practicing in hospitals so minority medical school graduates encountered severe restrictions in obtaining clinical training except principally at Howard and Meharry or at hospitals serving a minority and poor population. In New York State, Harlem Hospital and Montefiore Medical Center were among a handful of hospitals which had minority residents in training.

Beginning in the late 1960's and lasting through the mid 1970's, affirmative action programs were undertaken as a part of the general civil rights movement, to increase minority representation in medical schools and this had measurable results. In recent years, however, societal commitment to affirmative action has waned and the growth of minority physicians has fallen far behind the increase in the number of minorities in the population. In New York State, 25 percent of the citizens are black and Hispanic, but only about 4 percent of the physicians come from these groups. Out of the nearly 3,000 first year residents in training in New York, about 360 or 12 percent are underrepresented minorities, and more than 20 percent of the black first year residents are at Harlem Hospital, and over 20 percent of the Hispanics at Lincoln, Metropolitan and Montefiore Hospitals. Not only are there too few minority physicians in residency training in New York, but their underrepresentation in certain specialties and subspecialties is dramatic. For example, as of 1985, there were only 1 black and 5 Hispanic neurosurgeons in the entire state.

The New York State Council on Graduate Medical Education is committed to a significant increase in minority representation in residency programs and ultimately in the number of minority practitioners in the state. This is necessary in order to:

a. Remedy the effects of past discrimination;

b. Enrich the educational experience of all residents and medical students and better equip them to serve the heterogenous population of New York State;

c. Create a pool of minority physicians to serve as medical school and clinical faculty; and

d. Promote better health care delivery to underserved minority populations.

The Council therefore recommended:

1. Within a 4 year period, each teaching hospital in New York should have a percentage of underrepresented minority first year residents at least equal to the percentage of underrepresented minorities available in the pool of applicants.

2. Recognizing the limitations imposed by the number of minorities in medical schools due in part to poor educational preparation in secondary and college education, outreach programs to encourage and aid in the improvement of educational opportunities should be undertaken.

3. Residency programs should be attentive to the extensive underrepresentation of minorities within certain specialties and

subspecialties and affirmative efforts to rectify this deficiency are in order.

4. As institutions develop affirmative action plans, incentives to encourage programs should be developed.

5. Financial support for medical school scholarships are particularly critical to increase minority representation inasmuch as the rising tuition and associated expenses of medical education impose a major debt impediment to minority recruitment.

The implementation of some of these recommendations is already in existence such as outreach programs to increase educational opportunities and scholarships for minorities in medical school, and only need larger investments to improve the results. Change in minority representation in graduate medical education is likely to require a reallocation of existing funds to provide the requisite incentives.

ORGANIZATION OF GRADUATE MEDICAL EDUCATION - CONSORTIUM DEVELOPMENT

Graduate medical education in the U.S. has been hospital-based essentially since Benjamin Franklin opened the Pennsylvania Hospital in Philadelphia in the late 18th century. Initially, the residency training programs were free-standing, but now the majority are affiliated with a medical school. In New York, only 4 of the 500 residency programs are free-standing, and all of the rest are affiliated with one or another of the 12 medical schools in the state. In many instances, the affiliation is only nominal so that medical schools, hospitals, and other teaching sites are too often linked in superficial ways unrelated to educational needs.

The training of physicians for practice in the 21st century must encompass experiences in all aspects of medical care which will meet the health needs of that time, not of the 1970's or even 1980's. These will include the maintenance of independence and a good quality of life for as many of the aging population as possible; the chronic care of institutionalized elderly and of children with chronic disease or congenital disabilities; illness prevention, health promotion, diagnosis and management of the vast majority of medical problems seen in an ambulatory rather than an in-patient setting; experience and education in the medical care of patients in a community hospital as well as a tertiary care medical center. Recognizing that the relationships among affiliated institutions should be restructured to enhance the quality of education, improve efficiency, and make the system more responsive to current and future societal needs, the New York State Council on Graduate Medical Education concluded that this should be implemented by a defined consortium, consisting of the medical school, its affiliated hospitals and other teaching sites. Each consortium should:

1. Develop a written plan for the governance, coordination, and administration of residency programs that delineates the responsibilities of the medical school and each of its training sites,

for curriculum development, program operation, and educational resource allocation;

2. Monitor and evaluate the educational quality of all participating residency programs; and

3. Develop a written plan to enrich and improve the continuity between medical school and graduate medical education.

New York has the largest number of medical schools, residency training programs, and residents in training of any state in the U.S. There is great diversity with regard to population concentrations, demography, patterns of illness and organizational structures among the medical schools and their affiliated institutions. The Council therefore has recommended that each of the consortiums develop a plan designed to meet the defined objectives and submit them for review by the Council. A number are well along in planning and one consortium has developed a final plan for trial in 1989-90. Effective consortium development could increase efficiency by centralized administration of residency recruitment, stipend payment and of costs incurred at ambulatory training sites. The present mechanism of graduate medical education funding through reimbursement of the hospitals is a disincentive to meeting interinstitutional educational cooperation. Other financing mechanisms may be more consonant with the goals intended to facilitate the integration of programs, transfer of residents among facilities, prevent unnecessary duplications of resources. One such mechanism may be the "pooling" of graduate medical education funds. Other possibilities will be explored.

PROPOSAL FOR CONGRESSIONAL ACTION

In my opinion, there is a need to reinterpret the mission of graduate medical education in the light of changing issues. Graduate medical education is not a workshop to acquire knowledge and skills which can then be sold solely for personal gain, but rather it is to acquire skills and experience which will be used for community benefit. Graduate medical education programs that develop an organizational structure directed to state and national health needs should be recognized as qualitatively different from those residency programs with different orientations. As a society, we are encouraging or necessitating medical students and residents to be more responsive to markets with a lucrative return rather than to the health needs of populations.

I now wish to reiterate my opening suggestion. The support of graduate medical education is justified as a social good when it meets social needs. In order that this intent of Congress be realized, the broad characteristics of graduate medical education should be expressed in legislation together with a requirement that these be met in order to receive the Medicare subsidy. Each state would be asked to submit its plans for graduate medical education designed to meet state and national needs. This would be a part of the State Plan required of each state to meet Federal Financial Participation in the Medicaid Program. Eligibility and acceptance of the Graduate Medical Education component would not only have an impact on the Medicaid program but would determine the Medicare reimbursement as well.

Criteria which could be used to evaluate the eligibility of the state's plans in meeting the Legislative Intent should include:

- Increase in primary care specialties.

- Improvement in geographic distribution of future practitioners to favor underserved areas.

- Leadership in improving health status of people in defined geographic service areas.

- Increase in minority representation.

- Development of training in ambulatory care, long term care, and home care.

- Attention to cost effectiveness of health care services.

Chairman STARK. Thank you, Dr. Gellhorn.

Dr. Vanselow.

STATEMENT OF NEAL A. VANSELOW, M.D., CHAIRPERSON, COUNCIL ON GRADUATE MEDICAL EDUCATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES AND CHANCELLOR, TULANE MEDICAL CENTER, NEW ORLEANS, LA

Dr. VANSELOW. Thank you, Mr. Chairman.

I would like to concentrate my comments this morning on four specific areas related to graduate medical education or GME as I will call it. All of these were included in the Council on Graduate Medical Education's first report to Congress, which we submitted last July.

The first observation that I would like to make is a concern that our Council has expressed that graduate medical education is very important to the Nation, but its financial support is gradually being eroded, as both Government and the private sector attempt to moderate the rise in health care costs.

As you know, most financing for GME comes from funds paid for patient care. As these funds are becoming more constricted, there are no alternative sources of financing for residency training being developed. Our Council does not think we are at the point of crisis yet, but we think this is a cause for serious concern. And for that reason, we would urge caution in further reducing the Medicare support for GME.

The second observation is one that others have commented on. Our Council believes that there is now or soon will be an overall surplus of physicians in the United States but, at the same time, we've concluded that shortages continue in certain medical specialties, namely the primary care specialties of family medicine and general internal medicine, and in the field of geriatrics.

We believe these shortages are due in large part to two factors. First, and I think by far the most important, is that reimbursement to physicians in these specialties tends to be lower than for doctors in the procedurally oriented specialties. And this makes them less attractive to medical students.

Second, under Medicare, higher reimbursements are made to faculty and to teaching hospitals for procedural services and for inpatient care. The primary care disciplines and geriatrics emphasize cognitive rather than procedural skills, and they're largely conducted in an outpatient rather than an inpatient setting. They produce less revenue for the hospital and, therefore, there's less incentive for hospitals to support them.

To help correct this problem, we've recommended a number of things, including improved reimbursement through Medicare for training in ambulatory settings, and more adequate Medicare reimbursement for primary care physician services.

The third area I'd like to cover, Mr. Chairman, is the increasing importance of training residents in ambulatory care. It's quite clear that more and more health care is being provided in ambulatory settings. It's moving out of the hospital. As health care moves out of the hospital, it's essential that more residency training be conducted in outpatient sites.

There are a number of problems, however, with teaching outside the hospital. First of all, it's time consuming, both for patients and for physicians, and this makes it expensive. And, second, reimbursement for ambulatory care services is often lower than for inpatient services.

Finally, funding for GME is provided almost entirely through hospitals, largely from payments for inpatient services. It's difficult for ambulatory facilities to secure financing for the additional costs associated with the teaching program.

To addressed this problem, we've recommended the following: First of all, that all approved GME programs, including those based in ambulatory settings, should be eligible for Medicare GME reimbursement. We believe that a methodology for reimbursement of direct and indirect costs of ambulatory training should be developed.

We would also urge support through Medicare and private organizations for demonstration projects for alternative methods of payment for GME in ambulatory and other nontraditional settings.

Finally, I would like to make just a few observations about Medicare's indirect medical education adjustment.

First is that from the very beginning, this adjustment has been used as a proxy to reimburse teaching hospitals for a number of factors which increase their costs. Some of these are associated with graduate medical association. For example, the increased number of laboratory tests that residents order as part of the learning process. But other costs are not directly associated with teaching, such as urban and inner city location, sicker patients, and so on.

We believe that these other factors should be sorted out; that reimbursement for the expenses associated with them should be paid through other mechanisms. The problem is that to date, at least to the best of our knowledge, nobody has been successful in this sorting out process.

I'd also like to point out that the indirect medical education adjustment has already been reduced by about a third. The administration's recommendations for a further cut to 4.05 percent would reduce it by almost another third. This is of concern to our Council because there's evidence that suggests that teaching hospitals are beginning to experience financial difficulties.

Evidence has been presented to our Council that, while major teaching hospitals have had larger PPS margins than nonteaching hospitals, their total aggregate margins have been smaller than those of nonteaching hospitals. Also the PPS margins of teaching hospitals have been dropping significantly in recent years, and a number are already losing money on Medicare patients. This is certainly true at my hospital, Tulane University Hospital, where our costs for Medicare patients exceed our reimbursements by 3 percent.

For these reasons, our Council would urge caution enacting further reductions in the indirect medical education adjustment.

Thank you very much, Mr. Chairman, for allowing me the opportunity to testify today.

[The statement of Dr. Vanselow follows:]

STATEMENT BY
NEAL A. VANSELOW, M.D.
CHAIRPERSON
COUNCIL ON GRADUATE MEDICAL EDUCATION

I am pleased to have the opportunity to be with you today to discuss the financing of graduate medical education (GME). I am Chancellor of the Tulane Medical Center in New Orleans, but am here this morning in my capacity as Chairperson of the Council on Graduate Medical Education (COGME).

The Council on Graduate Medical Education, known as COGME, was established by Congress three years ago to provide advice and recommendations in three areas:

1. Physician manpower, including both the supply and distribution of physicians

2. Foreign medical graduates

3. Medical Education with particular emphasis on graduate medical education and its financing.

The Council has a ten year charter. Our First Report to the Congress and the Secretary of the Department of Health and Human Services was submitted July 1, 1988. We will be submitting additional reports at three year intervals until our legislative authority expires on September 30, 1996.

Before discussing some of the specific issues which we believe you should be considering relative to graduate medical education and its financing, I would like to say a word about the overall importance of GME to our nation.

Graduate medical education (also known as residency training) is a vital component in the education of tomorrow's physicians. A student graduating from medical school is ready for neither practice nor medical licensure. Three to seven years of additional residency training are needed to develop the knowledge, skills, and judgement required of today's physicians. It is during the GME period that physicians differentiate into specialties--the time when a physician becomes a specialist in a primary care discipline such as family medicine or in a more technical specialty such as surgery.

A second very important aspect of graduate medical education is that a significant portion of GME is made up of a service component. The roughly 80,000 residents on duty provide a great deal of patient care, much of it to indigent patients. Several years ago the Association of American Medical Colleges estimated that although teaching hospitals constituted less than 6% of the nation's acute care hospitals they provided more than 47% of the nation's free medical care. While theoretically it would be possible to hire others to deliver the indigent care now provided by residents, it would be very expensive.

A final general point I'd like to make is that the cost of graduate medical education is quite small relative to the Nation's total expenditures for health. A report issued by a Task Force established by the Commonwealth Fund noted that including the cost of GME in the patient's hospital bill was analogous to industry's practice of including labor training costs in the price of its products. This report also estimated that GME probably accounts for not more than 2% of the nation's health care expenditures and yet represents the "seed corn" of our health care delivery system.

I would now like to turn to four specific observations and issues which our Council feels you should consider as you deliberate about the financing of GME. Each of these was touched upon in our First Report to Congress.

The first observation is a concern expressed by the Council that, although important as GME is to the nation, its financial support is being gradually eroded as both government and the private sector attempt to moderate the rise in health care costs. Most GME financing comes through funds paid for patient care. As these funds become more constricted, there are no alternative sources of financing for residency training being developed. The Council does not believe we are at the point of crisis yet, but it is a cause for serious concern.

After a careful study of Medicare's contribution to GME financing and an examination of other financing alternatives for GME, the Council recommends that (a) Medicare payments for GME be maintained at current levels until more data is available on the potential impact of further reductions on teaching hospitals and training programs, and, (b) for the time being at least, the current method of providing reimbursement for direct and indirect costs be continued.

The Council has assigned a high priority to a continuing study of GME financing and will make further recommendations in future reports.

The second observation I would like to make is that while our Council believes there is or soon will be an overall surplus of physicians in the United States it has concluded that shortages continue in certain medical specialties--namely the primary care specialties of family medicine and general internal medicine and in geriatrics and the specialty of preventive medicine. We believe these shortages are due at least in part to two factors: First, reimbursement to physicians in these specialties tends to be lower than for physicians in the procedurally-oriented specialties. This makes them less attractive to medical students. Second, under Medicare higher reimbursements are made to faculty and to teaching hospitals for procedural services and for inpatient care. The primary care disciplines and geriatrics emphasize cognitive rather than procedural skills and are largely conducted in an outpatient rather than in an inpatient setting. They produce less revenue for hospitals and therefore there is less incentive for hospitals to support them.

To help correct this problem we have recommended the following:

a) expansion of existing Title VII grants for training in primary care;

b) improved reimbursement through Medicare for training in ambulatory settings; and

c) more adequate Medicare reimbursement for primary care physician services.

This brings me to the third area I'd like to discuss, namely the increasing importance of training residents in ambulatory settings.

It is quite clear that more and more health care is being provided in ambulatory settings rather than in the traditional inpatient setting. This is due in part to efforts to reduce health care costs, but also to new technology which makes it possible to perform diagnostic and treatment procedures in a non-invasive way.

As health care moves out of the hospital it is essential that more residency training be conducted in the ambulatory setting.

There are a number of problems, however, associated with teaching outside the hospital. First, it is time consuming for patients, which in addition to their inconvenience reduces patient care volume and revenues. Also, the costs of faculty and other staff are increased. Second, reimbursement for ambulatory care services is often lower than for inpatient services, which tends to discourage GME in ambulatory settings. Finally, funding for GME is provided almost entirely through hospitals, largely from payments for inpatient services. It is difficult for ambulatory facilities and entities other than those owned and operated by hospitals to secure financing for the additional costs associated with a teaching program.

To address these problems the Council recommended the following:

a) All approved GME programs, including those based in ambulatory settings, should be eligible for Medicare GME reimbursement. We believe a methodology for reimbursement of direct and indirect costs for ambulatory training should be developed.

b) We would urge support through Medicare and private organizations for demonstration projects of alternative methods of payment for GME in ambulatory and other non-traditional settings.

Finally, I would like to make a few observations about Medicare's indirect medical education adjustment.

The first is that from the beginning this adjustment has been used as a proxy to reimburse teaching hospitals for a number of factors which increase their costs. Some of these costs are associated with GME, for example the increased number of laboratory tests which residents order as part of the learning process. Other costs are not associated with teaching, such as urban and inner-city location, and sicker patients.

The Council believes that these other factors should be sorted out and reimbursement for the expenses associated with them should be paid through other mechanisms. Unfortunately, to the best of our knowledge nobody has yet been successful in this sorting out process.

I would also point out that the indirect medical education adjustment has already been reduced by about 1/3 and the Administration's recommendations for a further cut to 4.05% would reduce it by almost another third. This is of concern to those of us associated with teaching hospitals and to the Council because there is evidence that suggests teaching hospitals are beginning to experience financial difficulties. Evidence has been presented to our Council that, while major teaching hospitals have had larger PPS margins than non-teaching hospitals, their total aggregate margins have been smaller than those of non-teaching hospitals. Also, the PPS margins of teaching hospitals have been dropping significantly in recent years and a number are already losing money on Medicare patients. This is certainly true at my hospital, Tulane University Hospital, where our costs for Medicare patients exceed our reimbursement by 3%.

I would urge caution in enacting further reductions in the indirect medical education adjustment.

Thank you for allowing me the opportunity to testify today.

Chairman STARK. Dr. Anderson.

STATEMENT OF GERARD F. ANDERSON, PH.D., DIRECTOR OF THE CENTER FOR HOSPITAL FINANCE AND MANAGEMENT AND ASSOCIATE PROFESSOR, DEPARTMENT OF HEALTH POLICY AND MANAGEMENT, JOHNS HOPKINS UNIVERSITY

Mr. ANDERSON. Mr. Chairman, members of the committee, my name is Gerard Anderson. I am the director of the Johns Hopkins Center for Hospital Finance and Management and an associate professor in the department of health policy and management at Johns Hopkins University.

I should note with a little pride that our university has trained three-quarters of the staff of the professional staff members of your subcommittee, and I take special pride in Tricia Newman who has worked 3 years for me, and is still my doctoral student.

What I want to talk this morning about is, first of all, some of the problems with the current financing system for clinical education, and second of all, how a five-step plan would resolve the existing problems.

Any discussion of financing of clinical education should begin with a discussion of why Federal support is warranted, and there are four common rationales which are given.

The first rationale posits that clinical education benefits everyone, and therefore, it is the public good.

The problem with this argument is that if graduate medical education is considered a public good, then why should not undergraduate medical school training also be considered a public good? Why should public support of clinical training begin following graduation from medical school, and not at entrance to medical school?

The second rationale is that we should guarantee each medical school graduate a residency position. The problem with this argument is that it does not explain why public support of clinical education is warranted.

Other professionals, such as architects or social workers, require additional training as a prerequisite to licensure or certification, and they are not provided public support in a comparable fashion.

The third rationale, and the one which has driven public policy most recently, is the desire to maintain the academic medical centers. This has been argued in many different ways. Probably the most familiar is the assertion that we need to level the playing field, so that teaching hospitals are not disadvantaged in the competitive environment by a payment system that fails to take into account all the relevant factors that explain their relatively higher costs.

When I worked in the Office of the Secretary in the Department of Health and Human Services, I was a major proponent of this rationale and helped establish many of the concepts and payment methodologies for both direct and indirect medical education.

However, after further reflection, I am troubled by this rationale for several reasons. First, as the system currently operates, other payers do not generally pay for clinical education in a separate fashion.

While in the past other third party payers have contributed to clinical education indirectly through cross subsidies, many of them are now taking action, such as preferred provider arrangements, which have the effect of reducing substantially the payments to teaching hospitals.

The problems is that almost 90 percent of the revenues to pay for clinical education come from patient care revenues. In the future, Medicare and possibly Medicaid, will be the only payers to fund clinical education. This suggests that an alternative funding source must be found.

The fourth rationale is that Government should ensure that the appropriate quantity, specialty mix, geographic distributions of physicians is maintained. This is necessary to assure access to medical services.

My own view is that this is the only compelling rationale, and it forms the basis of my five-point plan for reforming the system of financing clinical education.

THE FIVE POINT PLAN

The basic principle behind this plan is to finance services provided to patients and to subsidize specific clinical education programs deemed to be in the public interest.

The first point is that you need to modify hospital and physician payments. I outline these specific reforms in my prepared remarks and will not go into those right now, given the time.

The second point is to eliminate all direct and indirect payments for clinical education. Studies of resident's activities show that most of the time residents are providing clinical services, primarily substituting for attending physicians. Very seldom do they substitute for nurses or other hospital personnel.

Most residents spend less than 25 percent of their time engaged in purely educational activities. As a result, additional payments to hospitals to support residents is inappropriate.

In this proposal, all payments under part A for residency training, including the salaries of residents and faculty and the administrative costs of the program, would be eliminated. All payments for indirect medical education would be eliminated.

Point 3. Allow all personal and identifiable physician services to be billed on a fee-for-service basis. Currently, 75 percent of the residents' time is spent on patient care, but they cannot bill for these services.

In this proposal, residents would be permitted to bill for personal and identifiable services. However, they would have to bill under the sponsorship of a larger entity, such as a faculty practice plan or a hospital, which would be responsible for their educational process.

Point 4. Establish specific requirements for residency education. In order to guarantee that quality programs are maintained, one possibility is to have the medical school certify that educational programs need a certain educational and quality standard. Residents would be unable to bill unless they were in a program approved by the medical school.

And point 5, Government sponsorship to fulfill specialty and geographic requirements. Some types of residency programs would be economically disadvantaged by this proposal.

Currently, the Bureau of Health Professions in the Public Health Service provides grants to promote specific residency programs. These programs could be expanded to include concerns about the geographic and specialty distribution, including those in ambulatory settings, and to assist programs which treat a large proportion of uncompensated care patients.

The benefits of this proposal, I believe, are quite substantial. First, it explicitly pays for services provided to patients. This will bring Medicare in concert with the private sector.

Second, there is no possibility of triple billing—first by attending physicians under part A for their supervisory role, second by attending physicians under part B for providing patient care services, and third by residents under part A for their own salaries.

Third, it eliminates the substantial variations across hospitals in the direct cost of training residents.

Fourth, it eliminates the whole discussion of how much to pay for indirect medical education.

Fifth, it would provide for better control of the educational process, and hopefully, better educational programs.

I believe this proposal is worthy of your consideration, and I would be happy to answer any questions.

[The statement of Mr. Anderson follows:]

STATEMENT OF GERARD F. ANDERSON, PH.D., JOHNS HOPKINS UNIVERSITY

Mr. Chairman, members of the Committee, my name is Gerard Anderson. I am Director of the Johns Hopkins Center for Hospital Finance and Management and an associate professor in the Department of Health Policy and Management at Johns Hopkins University.

I have been asked to talk about funding for clinical education. Specifically, I will discuss:

- **Why the Medicare Program pays for clinical education**
- **What are the problems with the current funding approach**
- **How a five-step plan for reforming the system of financing clinical education would resolve the existing problems.**

Why the Medicare Program Pays for Clinical Education

The federal government began funding clinical education programs the first day it paid for patient care services in teaching hospitals. Under cost-based reimbursement, all costs associated with clinical education were considered allowable costs.

When the Medicare and Medicaid programs were debated in 1965, Congress decided to finance clinical education from Part A as an interim measure until a better solution could be found. The founders of the Medicare program believed that the purpose of the Medicare program was to pay for patient care and not clinical education. In 1982, the Social Security Advisory Council, as part of its comprehensive review at the Medicare program, revisited this issue and began exploring other means of financing clinical education. The Council agreed that sources of revenue other than Medicare trust funds should be found but did not propose any specific methods.

Rationale for Financing Clinical Education

Any discussion of financing clinical education should begin with an agreement on why federal support is warranted. As I review the arguments in favor of federal funding of clinical education, four general rationales have been proposed. Clinical education is a:

- Public good;
- Every medical school graduate should be guaranteed a residency position;
- The federal government should maintain academic medical centers;
- The federal government should ensure that the appropriate quantity, specialty mix and geographic distribution of physicians is maintained.

The first rationale posits that clinical education benefits everyone and therefore it is a public good. I do not agree with this argument for two reasons. First, my economics training tells me that a public good is a service which can be provided at the same cost regardless of the number of people who use the service. The economist uses the coastal lighthouse as an example of a public good. Clearly, clinical education does not fit the definition of a public good used by economists since it costs more to train more residents.

A second and probably more compelling argument, however, is if graduate medical education is a public good, then why is not medical school training also considered a public good? Why should public support of clinical training begin following graduation from medical school and not at entrance to medical school?

The second rationale is that we should guarantee each medical school graduate a residency position. The argument is that the physician worked hard to finish medical school and he or she cannot practice without additional training. The problem with this argument is that it does not explain why public support of clinical education is warranted. Other professionals such as architects or social workers require additional training as a prerequisite to licensure or certification and they are not provided public support in a comparable fashion.

The third rationale, and the one which has driven public policy recently, is to maintain academic medical centers. This is argued in many different ways. Probably the most familiar is the assertion that we need to "level the playing field", so that teaching hospitals are not disadvantaged in the competitive environment by a payment system that fails to take into account all the relevant factors that explain their relatively higher costs. The specifics of this argument will be discussed in much greater detail by members of your third panel today. When I worked in the Office of the Secretary at DHHS, I was a major proponent of this rationale and helped establish the concepts and payment methodologies for both direct and indirect medical education.

After further reflection, however, I am troubled by this rationale for several reasons. First, as the system currently operates, the other payors, such as Blue Cross, Commercial insurers and Health Maintenance Organizations, do not pay for clinical education separately. While in the past other third party payors contributed to clinical education indirectly through cross subsidies, many of them are taking actions such as preferred provider arrangements which have the effect of reducing payments to teaching hospitals. The problem is that almost 90 percent of the revenues to pay for clinical education come from patient care services. In the near future, Medicare and possibly Medicaid, will be the only payors to explicitly fund clinical education. This suggests an alternative funding source must be found.

In addition, I have other concerns with the objective of maintaining the existing number of academic medical centers. It is unclear whether or not the current number of institutions providing clinical education is correct. Why should each institution be guaranteed its current level of residency positions? Do we have the correct mix of specialties or geographic distribution of residency programs? Moreover, why should Medicare continue to pay for large variations in direct medical education expenditures per resident from hospital to hospital?

The fourth rationale is that the government should ensure that the appropriate quantity, specialty mix, and geographic distribution of physicians are maintained. This is necessary to ensure access to medical services. My own view is that this is the only compelling rationale and it forms the basis for my five point plan for reforming the system of financing clinical education.

Five Point Plan

The basic principle behind this plan is to finance services provided to patients and to subsidize specific clinical education programs deemed to be in the public interest.

Point One - Modify Hospital and Physician Payments

Certain modifications to hospital and physician payment are necessary before clinical education financing systems can be reformed. Reform of clinical education financing cannot operate in a vacuum. Many of these proposals will be discussed in your second panel today.

The PPRC is reviewing a number of options to reform the physician payment system including relative value scales. Financing of clinical education programs must work in concert with physician payment and cannot be expected to undo the problems created by the current system of paying physicians.

ProPAC is examining a number of options to revise the hospital payment system. Many of these proposed adjustments would lower the adjustment in the "catch all" category currently mislabeled as indirect medical education and pay for these services explicitly as patient care services.

The most significant is an incorporation of a severity of illness adjustment such as the revised DRG's recently developed at Yale or the computerized severity of illness measure that has been developed at the Johns Hopkins Center for Hospital Finance and Management.

Adjustment for input costs is also critical. Teaching hospitals which are generally located in inner city environments and therefore may have to pay higher wages hire additional staff such as security personnel, and pay higher non labor costs. The proposal to equalize urban and rural payment rates would seriously disadvantage teaching hospitals. In fact, research suggest that an adjustment for inner city location is warranted.

Since many residents provide care to individuals without health insurance, it is also necessary to find a way to help hospitals which treat a disproportionate number of uninsured. Many of the services provided by residents become uncompensated care.

Point Two - Eliminate All Direct and Indirect Payments for Clinical Education

Studies of resident's activities show that most of the time, residents are performing clinical services, primarily substituting for attending physicians. Very seldom are they substituting for nurses or other hospital personnel. Most residents spend less than 25 percent of their time engaged in purely educational activities. As a result, payments to hospitals to support residents is inappropriate.

In this proposal, all payments under Part A for residency training, including the salaries of residents and faculty and the administrative costs of the program, would be eliminated. All payments for indirect medical education would be eliminated.

Point Three - Allow All Personnel and Identifiable Physician Services To Be Billed on a Fee-For-Service Basis

Currently, 75 percent of the residents time is spent on patient care, but they cannot bill for these services. In this proposal, residents would be permitted to bill for personal and identifiable services. However, they would have to bill under the sponsorship of larger entity such as a faculty practice plan or the hospital which would be responsible for their educational progress. In order to pay for themselves, residents would have to collect $40,000 worth of billings each year. If this were not economically viable, residents salaries could be lowered or subsidized using other funds.

If the physician community believed that residents in their first year of training should not bill for services, then they could pay a tuition during that year or not receive a stipend. Remember, however, first year residents are now providing patient care services and nothing would have to change under this proposal.

Point Four - Establish Specific Requirements for Residency Education

Currently, the government, which finances a large share of the cost of clinical education, has a limited role in determining in establishing standards for training. It has limited role in determining the specialty and geographic distribution of residency programs. It may, therefore, be appropriate and beneficial to institute government review in order to assure that educational programs continue to be of high quality.

A second and probably more politically acceptable alternative would be is to have medical schools certify that residency education programs meet a certain educational and quality standard. Residents would be unable to bill unless they were in a program approved by a medical school.

Point Five - Government Sponsorship to Fulfill Specialty and Geographic Requirements

Some types of residency programs would be economically disadvantaged by this proposal. This could be rectified by a government grant program. Currently, the Bureau of Health Professions in the Public Health Service provides grants to promote specific residency programs. If necessary, this could be expanded to other programs which are not self sufficient. It could be used to expand the geographic or specialty distribution and to assist programs which treat a large portion of uncompensated care patients.

Limitations of This Proposal

I recognize that this proposal presents a number of changes that will demand further attention. First, it may require Medicare beneficiaries to pay a higher premium since they pay part of the cost of Part B. My guess, however, is that the incremental cost to beneficiaries would be small - much less than $1.00 per year. Second, certain specialties may be more able to sponsor residency programs than others. Under current payment rates, the procedure oriented specialties would be more able to sponsor programs than the cognitive specialties. However, with the advent of physician payment reform and government sponsorship of specific programs, any adverse impact could be minimized. Third, the cost impact is uncertain. Estimates I have made using a federally sponsored study of financing of graduate medical education suggest that it will be cost saving, but additional work is clearly necessary. Fourth, the five point plan cannot be implemented immediately. It is contingent upon certain reforms in hospital and physician payment methodology which the Congress is discussing. I believe, however, it can form the blueprint for discussion of this issue during the next several years.

Benefits of This Proposal

The benefits of this approach, I believe, are substantial. First, it explicitly pays for services provided to patients. This will bring Medicare in concert with the private sector and get Medicare out of the clinical education debate.

Second, there is no possibility of triple billing - first by attending physicians under Part A for their supervisory role, second by attending physicians under Part B for providing patient care services, and third by residents under Part A for residents salaries.

Third, it eliminates the substantial variations across hospitals in the direct cost of training residents.

Fourth, it eliminates the discussion of how much to pay for indirect medical education.

Fifth, it would provide for better control of the educational process and hopefully better educational programs. There will be closer monitoring of hospital educational programs by outside organizations such as medical schools or government.

Sixth, it could lead to better specialty and geographic mix of residency programs.

I believe this proposal is worthy of your consideration and I would be happy to answer any questions.

Chairman STARK. I think you hit the nail right on the head. The only problem I have, Doctor, is how do I sneak more money into the innercity hospitals if I cannot do it under the guise of graduate medical education?

Mr. ANDERSON. Well, you have the disproportionate share adjustments. You have a whole variety of hospitals——

Chairman STARK. I cannot get as many votes for that. I can log roll the graduate medical education, and——

Mr. ANDERSON. Right, you certainly can do that.

Chairman STARK. I cannot——

Mr. ANDERSON. This is one solution to solve one problem. It is very difficult to solve all of them with graduate medical education.

Chairman STARK. What a web we weave when first we practice to deceive.

Mr. ANDERSON. Correct.

Chairman STARK. Deceiving the Budget Committee is sometimes a trickier proposition than you can imagine.

We are about to go through the drill of discussing reimbursements, and in the process of wondering what to do and reviewing various reimbursement plans, some of us have spent some time in Canada trying to see what happens there.

I am not sure if we can transplant anything, but one of the results, or one of the facts of life in Canada, is that there are many more primary care physicians, relative to surgical specialties, than there are in this country. And arguably, the primary care "docs" make more money in Canada, relative to the superstars of surgery, than here.

I am not sure whether their reimbursement plan has—whether that is a cause or an effect, but I am wondering—I do not know whether that is the supply or the demand side, but in any rate, whether a change—there seems to be a strong incentive built in, kind of a fee for service for high priced procedures.

As an economic incentive, it ought to drive people into those special fees, and indeed, once in them, it ought to encourage them to perform the procedures they have been trained to perform for which they get high fees.

If a change in the payment procedures were to come about in this country, and I doubt if anything as drastic as universal capitation would be even a political possibility, much less a reality—do you foresee that that would impact on the change in the way people sign up for specialties?

[Pause.]

Chairman STARK. Anybody, please?

Dr. GELLHORN. Well, I think very significantly, as you point out, one of the mechanisms in Canada has to deal with a differential reimbursement for the primary care, and it works very effectively—not completely, because they still have areas in very remote parts of Canada where they still have real problems getting people out, but it is so much better than what we do, and they do have universal access, which we do not have.

One of the things that I cannot understand, Mr. Chairman, is why our reimbursement for Medicaid patients, as compared with Medicare patients, is so desperately different.

Chairman STARK. Because unthinking people like Governor Duekmejian are trying to balance the California budget on the backs of the poor——

Dr. GELLHORN. I understand that, but Congress could also do something. Gradually, you said that the reimbursement for the poor——

Chairman STARK. I have a bill to do just that. I mean, to make Medicaid at a minimum of 90 percent of the Medicare reimbursements——

Dr. GELLHORN. Right on.

Chairman STARK [continuing]. And your support for that bill would be appreciated.

You are right. That is where sequestering came into vogue, as in the 1970's we can appropriate money, but there is nothing that says people have to spend it. You can break the Medicaid system apart by not spending the money.

Now, arguably, forcing States like Mississippi, even with as little as they put into Medicaid, to pay reasonable fees, could have an impact, and I think that those of us from States that are wealthier are going to have to swallow the political pill and say, "OK, we are going to have to bail out the poorer States." That does not trouble me. California has got a lot of money relative to some of those States. I guess we are going to have to pay it, but it has got to come.

You know, I do not know, except the fact that Henry Waxman does such a good job with his subcommittee, why we have two systems. It just does not make any sense to me, and maybe you gentlemen can make more sense out of why we have two provider systems for the Government. Doctor.

Dr. VANSELOW. Mr. Chairman, I am not going to try to make sense out of that, but I did want to respond to your question.

I want to disagree with Dr. Lee who felt the major reason that people were not going into primary care was the fact that we supported biomedical research at the end of World War II. I think that was one of the best decisions this country ever made.

I think the single most important factor is reimbursement. I have talked to a lot of medical students. They do not want to go into a primary care discipline. They know they are going to work long hours. They are going to be up at night, and they are not going to be reimbursed nearly as well as their colleagues who go into surgery or optometry.

If there was any one thing Congress could do, I think it would be to improve the reimbursement for primary care physicians.

Chairman STARK. Oh, I could not agree more. You know, that is not a pejorative sense or it is not a critical sense, it is just that the differences are so astounding and the hours.

I mean, my God, a pediatrician has got to be the most underpaid, overworked person in your profession, and my kids never got sick during daylight hours, and [laughter] my ability to deal rationally with it in those hours when they were sick was minuscule, but as long as the phone was handy, I did not mind calling Dr. Cook. It just escapes me why we are doing that.

God forbid that this committee should get involved in the practice of medicine. For both Dr. Sammon and I, it is one of the fears we both share [laughter] but it does seem to me that what could happen to us just in the long-range practice of medicine, we should do more preventive stuff.

I do not know why a heart surgeon should tell me to get my cholesterol down. First of all, I do not go to ask him about that, and second, it is probably a disincentive, because if he knows I continue to do stupid things, he will see me in a much more profitable mode than he will if he just gives me advice I do not take.

Somehow managing our health care is something that has to be done, and I do not think we should do it, but I do not know why we keep reinforcing disincentives to do what I suspect you all would agree as the right way to proceed.

Mrs. Johnson.

Mrs. **Johnson**. Just as an aside, I think we are beginning to see in pediatrics the same subspecialty development that we are seeing in those disease areas for middle-aged Americans and older Americans.

If you look at pediatric cardiologists and the incredible number of hours and years of training they take in the cost, they are going to put on us a neonatal expertise and all of that. So I think right now we can talk about some kind of disparity among subspecialties, but I do not think that is going to be true in 5 or 10 years, and I do not think we are preparing for it very well.

Two questions. First of all, those of you who talked about ambulatory training, and the way our reimbursement system rewards institutional training over the training in other settings. First of all, how can we change that?

Second, directly relevant to the debate this subcommittee is going to engage in in the next month or two, would that reduce the overall cost of training, or would it be simply an expenditure on different items?

In other words, should we see that need both as requiring us to change the way we spend money and also as a license to reduce expenditures, or should we see that as only the former or only the latter?

Each one of the panelists.

Dr. **Gellhorn**. Well, Mrs. Johnson, I certainly do not think it would reduce it. On the contrary, the training in ambulatory medicine is more complicated by a long shot than training in the hospital.

In the hospital you have a captive audience, and the people that are being the subject of education do not move. They cannot move. Whereas in the ambulatory area, you have to meet the demands of people who do not wish to spend a whole day coming in and out, and therefore, it is very much more complicated. I think that the costs are going to be as great if not greater.

On the other hand, this does not diminish the fact that, at the present time, our young physicians are not having the experience of meeting a patient who does not come in with a diagnosis. They are not meeting the undifferentiated sort of problem.

Mrs. **Johnson**. But would it not be a very simple matter to require that residencies provide some of their training in community based facilities, or however you want to define that——

Dr. GELLHORN. But that has to be subsidized. That has to be subsidized. The costs are very considerable. You have not only the costs of faculty, which are not going to be so easy to come by, but there are costs that are associated with the efficiency of the—particularly in the ambulatory setting, is very remarkably reduced, even much more so than in the hospital. Therefore, the costs are great.

Thus, for example, in the area of family medicine, that is a subsidized residency, solely because so much of the training in family medicine is done on an ambulatory basis, and therefore, it should be extended to the other primary care specialties.

Mr. ANDERSON. I think it is three problems. First, the costs are greater in an ambulatory care setting, even for doing the same procedures. Simply because the hospital is not always established to do those same procedures as well. I mean, you have the whole infrastructure of the hospital.

Second, the payments are generally less when you do it on an outpatient basis than an inpatient basis.

Third, you have got to look at the patients which are treated on an outpatient basis. You have a much higher percentage of uncompensated care, because the people do not have the health insurance, and they are the ones that go many times to the ambulatory settings that the hospitals operate.

So you have really three problems which make training in ambulatory care settings very difficult.

Dr. VANSELOW. I agree that we probably would not save any money if we had more training in ambulatory care settings. Maybe an example would help.

As a physician, if I make rounds with students and residents—I have to make rounds anyway everyday, and I can work teaching in fairly easily.

In the outpatient setting, whereas I used to find that I might be able to see 10 patients in an afternoon if I were by myself, if I had a student or resident, every time we saw a patient, we would have to stop and teach, and I might be able to see only half that number. So it is really very expensive.

I think some things that can be done are to reimburse programs—residency programs—that are not necessarily based in hospitals—not just reimburse through hospitals, but if a program is based in a large group practice or in an HMO, to reimburse directly.

Second, you might want to consider differential reimbursement, perhaps the indirect medical education payments for time spent in an ambulatory setting.

Finally, another thing that has been a big problem, is that very often the same procedure performed in an ambulatory setting is reimbursed at a lower rate than that procedure performed in an inpatient setting, and that might be corrected.

Mrs. JOHNSON. Thank you. No more questions, Mr. Chairman.

Chairman STARK. Mr. Levin.

[No response.]

Chairman STARK. Mr. Pickle.

Mr. PICKLE. Well, Mr. Chairman, thank you.

I was not here when Dr. Lee testified. I am going to read his testimony and review yours too.

When we started the extra payments a few years ago, there was a feeling in the Congress that costs in teaching schools were higher than in normal hospitals, and we should provide an extra payment rate.

Do any of you disagree with that basic premise, that it is more expensive?

Mr. ANDERSON. Well, it depends on what you look at, and what kinds of adjustment factors you in fact make, and whether or not you consider both the hospital and the physician or simply the hospital.

I would agree that the hospital is substantially more costly. You make a whole series of adjustments in the Medicare perspective payment system, and in my testimony I suggest some other ones.

However, when you look at what happens when the hospital and the physician together, many times it costs more money to train a resident—by the physician because it takes more time to train resident. In certain times, it takes less time to train a resident.

You do not have to get up at 3 o'clock in the morning, because there is a resident around. So for certain times, it is less expensive, so you have got to take a look at the total——

Mr. PICKLE. Well, I do not think I would disagree with you on that, but in general, the costs are higher because they are treating patients who are more severely ill and who have less money. Somebody has got to treat them.

Mr. ANDERSON. Right.

Mr. PICKLE. We have to share that cost. So there is a recognition that some consideration should be given to that responsibility. Now, the question is, how to go about it?

The administration has recommended cutting the indirect payments from about 7.7 percent—down to 4. That is nearly a 50-percent cut, and that is a severe cut for that kind of a hospital. The administration has also recommended a cut in the direct payments.

I understand that Dr. Lee had recommended that he would cut back training in certain specialties that would create a big savings. I do not see how that could save upward of $1 billion that he was talking about, but at least that is the approach.

Congress is considering basic reforms on how Medicare pays doctors to eliminate incentives to the subspecialties, so I will ask you, is it more appropriate that to do than tinker with medical education payments?

Dr. GELLHORN. Mr. Pickle, I think that you have to tinker with graduate medical education, because the evidence is abundant that where one has one's training and the type of training that one has, also determines what one does afterward.

In New York, 80 percent of the practicing physicians have had their graduate medical education in the State, and people do not get trained as cardiac surgeons, and then go out and do primary care.

So I think if you are concerned, as I gather you are, with the characteristics of the specialties, then you have to be concerned with graduate medical education.

Mr. PICKLE. I am concerned to the extent that I recognize that if these physician costs are out of line and we have to make some reduction, then the question is, where do you make it, and it is not inappropriate to consider a different approach. I do not disagree with that.

I do disagree, seriously, with making big changes in the teaching school. I have got a school in my own State, my University of Texas, which incurs extremely high costs. To say that we are just going to change medical payments without a clear plan could be harmful.

I would rather try to establish first what kind of payments should we have before we start changing to change it formally. It seems to me that ought to be established before we just automatically take a pencil and made a reduction.

Dr. GELLHORN. Oh, I could not agree with you more. My testimony really is not addressed to the reduction, but really to a definition of what that graduate medical education subsidy should be used for.

Mr. PICKLE. Well, I take it that this panel, each one of you, is posing different ways to go about that definition. Dr. Anderson would eliminate all direct and indirect medical education payment, and that got my attention right quick. [Laughter.]

Which one is Dr. Anderson?

Mr. ANDERSON. The middle one.

Mr. PICKLE. But I also know that you make some proposal as to how you do it, that I guess the residents—by residents, I assume you mean training doctor?

Mr. ANDERSON. Yes.

Mr. PICKLE. Pretty much establish their costability. Now, how do you control what those fellows do if you did that? It seems to me that might cost us even more than the present program.

But I also take it that what you recommend—each of you—is to say you might do one of three or four different things, and this is a sort of exploring session to give us something new to think about. I think that is not unreasonable, but I am serving notice now that I do not want to see these payments cut in these hospitals if they are really rendering a great service, and there are not many other places for their indigent patients to receive care.

If there is a recognition that teaching hospitals provide needed care then we ought not to be tinkering with cutting these payments out until we know just what is the problem.

Dr. VANSELOW. Mr. Pickle, I would like to comment if I could——

Mr. PICKLE. Yeah.

Dr. VANSELOW [continuing]. On that, and also on Dr. Anderson's proposal. I think about 25 percent of the payments to major teaching hospitals through Medicare are composed of the indirect medical education adjustment and the disproportionate share adjustment. That is a lot of money.

Somehow, more and more of these teaching hospitals are losing money now, and I think if the indirect medical education adjustment were cut to 4.05 percent, it would be a disaster for some, and there would be an enormous problem in most major teaching hospitals.

I had not heard Dr. Anderson's proposal before. I just want to make a few observations about it.

Graduate medical education is a time of both education and a time when service is delivered. It seems to me if you pay residents on a fee-for-service basis, all you are emphasizing is the service aspect.

Second, if you do not provide any reimbursement for the supervising physicians, I would have great concern about supervision, and that is something that has been a big problem in this country, that residents have not been adequately supervised, and we have all read about that in the paper.

Finally, if we are going to get more primary care physicians, and we reimburse residents based upon the service they deliver, we know that the reimbursement is going to be less for family practice residents and general internal medicine residents, and very high for surgeons. It seems to me we are moving in the wrong direction.

Mr. PICKLE. Had you had a chance to look at Dr. Anderson's proposal before you got here this morning?

Dr. VANSELOW. No, I had not.

Mr. PICKLE. Then you are just as surprised as we are up here then?

Dr. VANSELOW. Right. This is right off the top of my head, Mr. Pickle.

Mr. ANDERSON. Well, let me try to respond to those concerns.

First of all, in terms of supervision as Dr. Vanselow said, they are not being, many times, well supervised currently. What I proposed to do is have the medical school get in there and supervise the residency programs in the teaching hospitals, so that they would have to be certified in order to get paid by the Medicare Program. Then it is an adequate educational experience.

Second of all, the whole question of whether or not there is a need to change the current system and to pay for primary care residencies differently in that concern, I think that it is important to pay for primary care. I think that Dr. Lee's perspective—Physician Payment Reform Commission will do that.

I also think that what I have proposed in here is some supplemental funding for certain primary care programs as part of the Bureau of Health Professions in the Public Health Service, so if you believe that you should subsidize certain residency programs, my proposal would do that.

In terms of the total cost, I think you need to take a look at the Congressional Budget Office, and ask them to cost out an idea like this, because I am not equipped to do it.

The estimates that I have done suggest that, in fact, it would be cost savings, but they are based upon my estimates and certainly cannot compete with the resources that CBO has.

Mr. PICKLE. I raised a question just a minute ago that I am not sure whether your proposal would end up costing us more or saving us money, but I think it is a legitimate question to raise, and I think we should ask the CBO to give us some estimate to that figure.

Mr. Chairman, I thank you for this. I just raise a question whether we should consider changing medical education payment before we understand the impact of changing payments to doctors. I think this is something we ought to consider as we go along here.

Thank you, Mr. Chairman.

Chairman Stark. Thank you.

I want to thank the panel. Unfortunately, it would be unfair to the rest of the witnesses for me to engage you, Dr. Anderson, in a discussion of how Medicare fees are responsible for the disappearance of so many hospitals, because we underpay them so tragically, but I will——

Mr. Anderson. I had the opportunity to talk to you last year about that issue.

Chairman Stark. Is the same testimony good this year?

Mr. Anderson. Same testimony.

Chairman Stark. I will just drive that hearse up again in front of the tape and replay it.

I want to thank the entire panel. Dr. Gellhorn, your reputation for a long and devoted service in this area precedes you, and I appreciate the work you have done on your commission.

Dr. Vanselow, also, thank you for your concern in helping us solve this problem. I think it is a tinker's effort to chance play, and we have to keep all of the—or it is a three-card Molly if that is a game you prefer.

Which shell the pea is under at any one time is a matter of concern in this budget process, but it is all interrelated, and we are dealing currently with each of the problems—reimbursement, how we fund hospitals, and what we are going to do about changing, if anything—how we affect the change in the practice of medicine.

I hope you will continue to work with us and counsel us. It is appreciated. Thank you all very much.

Mr. Anderson. Thank you.

Dr. Vanselow. Thank you.

Dr. Gellhorn. Thank you.

Chairman Stark. Our next witnesses are a panel consisting of Michael Zimmerman, Director of Medicare-Medicaid issues with the GAO, and Dr. Ken Thorpe, director of the program of health care financing and insurance, professor of economics at the Harvard University School of Public Health.

Gentlemen, it's good to see both of you again. The disclaimer is that you are not here as paid members of the Health Subcommittee staff, but are here as independent witnesses, and we appreciate your being here. Your full testimony will appear in the record. Mike, would you like to lead off?

STATEMENT OF MICHAEL ZIMMERMAN, DIRECTOR OF MEDICARE AND MEDICAID ISSUES, HUMAN RESOURCES DIVISION, U.S. GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY TOM DOWDAL, ASSISTANT DIRECTOR, HEALTH FINANCE AREA

Mr. Zimmerman. Sure, thank you very much. Mr. Chairman, we've got three charts with us today. I apologize to those in the audience who can't see past them. Unfortunately, we have one size chart in the GAO regardless of the size of the hearing room. [Laughter.]

Also, my statement does contain the tables that are shown on the chart. So, for those of you who can't see the charts, they're included in the statement.

Let me begin by introducing Mr. Tom Dowdal, who's with me today. He's an Assistant Director in charge of much of our Medicare work.

We are pleased that you asked us to be here today, to discuss our January 1989, report on Medicare's indirect medical education payments to teaching hospitals. Teaching hospitals conduct graduate medical education programs to train interns and residents and for this they receive additional payments from Medicare.

First, they receive payments based on the direct costs of the Education Program for such items as classroom space and instructor salaries. Second, teaching hospital payments are adjusted upward to compensate them for the indirect costs of medical education thought to be associated with such factors as increased diagnostic testing, increased number of procedures performed, higher staff ratios, and increased record keeping. Current law provides an indirect medical education adjustment factor of 7.65 percent for each one-tenth increase in the intern-to-bed ratio.

The 1985 Budget Act directed us to study the variation in Medicare payments among teaching hospitals and between teaching and nonteaching hospitals. We were also asked to account for the reasons for such differences, to the extent feasible. The report we are discussing today presents the results of our study.

As the first step in our analysis, we used cost reports from about 4,100 hospitals to determine the average costs and average payment for Medicare discharges. Our analyses show that on average, Medicare teaching hospitals received 106 percent more in payments per discharge, and had 95 percent higher costs per discharge than did nonteaching hospitals. Minor teaching hospital payments were 45 percent higher per discharge, while their costs were 40 percent higher per discharge than those of nonteaching hospitals.

Studies have shown that most of the variation in hospital costs to treat Medicare patients is explained by specific factors affecting input prices such as location and specific output variables such as the mix of patients treated and the presence of a graduate medical education program. Also, hospital costs are related to size which, in turn, is correlated with input prices and output. We gathered data on various factors that affected hospital costs for major and minor teaching hospitals, and nonteaching hospitals.

As you can see from the chart on my left, major teaching hospitals consistently show measures of these factors that indicate costs will be high. And, while minor teaching hospitals do not have measures as high as major teaching hospitals, nevertheless, theirs are generally higher than those of nonteaching hospitals.

For example, the average case mix indexes of the three groups show that patients treated at major teaching hospitals would be expected, on average, to be 17 percent more costly to treat than those at nonteaching hospitals and patients at minor teaching hospitals, about 11 percent more costly. Also, the average wage indexes show an even more drastic difference among the hospital groups where major teaching hospitals having an average index of 19 percent and minor ones 12 percent higher than nonteaching hospitals.

Thus, these two factors, case mix and wages, account for much of the difference in average costs among hospital groups and PPS rates are adjusted for these factors.

In summary, it has been shown that there is a positive relationship between Medicare costs and such factors as hospital patient mix, location, and size. In addition, as can be seen from the chart on my left, there is also a positive relationship between these factors and the teaching status of hospitals. These factors, rather than the presence of a teaching program, per se, help explain a large portion of the higher costs at teaching hospitals.

Our analysis concludes that after accounting for factors discussed above, teaching hospitals still have higher costs than nonteaching hospitals. This remaining cost difference has been attributed to the indirect costs of medical education.

Given the imprecise nature of the indirect costs of medical education, and the absence of a conventional way of measuring them, policymakers have used regression analysis as a means of adjusting PPS payment rates to reflect indirect costs. Using fiscal year 1985 data on 8 million Medicare discharges from about 5,400 hospitals, we applied regression analysis to estimate the relationship between graduate medical education and Medicare operating costs per discharge with a number of different approaches, and examined the policy implications of each.

Specifically, we examined the differences in estimates obtained by adjusting, explicitly, only for the effect of the factors currently considered in setting hospital payment rates and three analyses that include additional cost factors. We also discussed the differences, from doing the analysis with and without outliers, and limiting the value of certain variables used in the models to their theoretical PPS payment value.

The second chart I have, which is the one furthest on my right, shows the cost factors considered in the four different approaches, or models.

For each of the four models we computed estimates by, both including and excluding, outlier cases for which hospitals receive extra payments from Medicare. Moreover, we also computed estimates where case mix and wages were constrained to their theoretical values.

The next chart I have, which is closest to me on the right, presents the 12 estimates of the indirect effect of teaching on costs per Medicare discharge that resulted from our analysis. As you can see, estimates range from 3.73 to 7.19 percent. And, all of these estimates are lower than the 7.65 percent adjustment factor currently specified by law.

Selecting one of these estimates to be used as an adjustment factor is a policy decision. However, the choice affects all hospitals, not just teaching hospitals because under PPS, the total amount paid to hospitals remains the same when adjustments are made for particular hospitals, or group of hospitals. Paying more to teaching hospitals results in paying less to the others.

We recommended, in our report, that the Congress reduce the teaching adjustment factor for 1989, and beyond. We concluded that our estimate of 5.09 percent represents the best option for determining the additional payments to teaching hospitals for fiscal years 1990–95. Our reasons for this conclusion are fully explained in the report, and I will only highlight them here.

The 5.09-percent estimate considers, essentially, the same factors that would be used to determine PPS rates during the period and is generally free from the influence of other issues affecting these rates.

First, the estimate does not include the effect of outlier cases, which involve extremely high costs or long lengths of stay. Including outliers would compensate teaching hospitals more equitably for such cases, but equity would not be improved for the other hospitals with outlier cases. We believe it's preferable that any shortcomings in outlier policy be addressed by revising that policy so that all hospitals are treated equally.

Second, the 5.09-percent estimate was computed without limiting case mix and wages to their theoretical values. If these factors are limited, teaching hospitals would be compensated for potential shortcomings in the current PPS rates related to the two factors, but other hospitals would not. Again, we believe it's preferable to address any shortcomings directly by modifying case mix and wage index policies so that all hospitals benefit.

If the 5.09-percent estimate was used, the payments to teaching hospitals would be reduced by $808 million in fiscal year 1990, $991 million in fiscal year 1991, and $1.1 billion in fiscal year 1992.

If the Congress decides to reduce the adjustment factor, as we believe it should, and, if the Congress wants to use the reduced payments to teaching hospitals to lower overall Medicare outlays, the legislation would have to specifically reflect that decision. Otherwise, under current law, the reduction for teaching hospitals would be offset by increases in payments to nonteaching hospitals.

That completes my statement, Mr. Chairman. I'll be glad to answer any questions you may have.

[The statement of Mr. Zimmerman follows:]

STATEMENT OF MICHAEL ZIMMERMAN, DIRECTOR OF MEDICARE AND MEDICAID ISSUES, HUMAN RESOURCES DIVISION, U.S. GENERAL ACCOUNTING OFFICE

We are pleased that you asked us to be here today to discuss our report on Medicare's indirect medical education payments to teaching hospitals.[1] These payments are intended to compensate hospitals' higher patient care costs associated with graduate medical education. We found that teaching hospitals have significantly higher costs but most of the difference in costs between teaching and nonteaching hospitals is explained by such factors as the mix of patients treated and geographic location that affect hospital costs irrespective of a teaching program. The residual or remaining cost difference--the amount attributed to the indirect costs of medical education--varies depending on the number and types of other cost-influencing factors considered in the analysis.

Our report presents a number of estimates of the indirect effect of medical education on hospital costs. All of the estimates are lower than the adjustment factor currently specified by law. Our estimates of the increase in hospital operating costs ranged from 3.73 to 6.26 percent for each increment of 0.1 in the intern-to-bed ratio. The estimate of 5.09 percent considers only the cost factors currently used in PPS, but measures them more accurately. We believe that this estimate is the one most consistent with how Medicare's hospital prospective payment system (PPS) is currently structured.

In our report we recommended that the Congress reduce the teaching adjustment factor for fiscal years 1989 and beyond to the levels shown by our analysis of Medicare hospital costs.

BACKGROUND

Medicare's PPS sets in advance the payment rates hospitals will receive for their operating costs. Each patient is placed into 1 of 470 payment groups--called diagnosis related groups--based on the patient's diagnosis. The amount a hospital receives for its operating costs is determined by two factors--the "weight" of the DRG into which the patient was classified and the standard payment amount for the discharging hospital. The weight for a given DRG represents the national average resources used to care for Medicare patients in that DRG relative to the national average resources used to treat all Medicare patients. The DRG weight is multiplied by the discharging hospital's standard payment amount, which is the national average cost of treating a Medicare patient, adjusted to reflect wage rates in the hospital's area and the hospital's location (urban or rural).

Besides the PPS payment for operating costs, all hospitals are paid an amount to cover their capital costs based on the actual amount of these costs. In addition, PPS payments are adjusted upward, if a hospital treats a disproportionate share of low-income Medicare beneficiaries[2].

A hospital that conducts a graduate medical education program to train interns and residents receives additional payments from Medicare. First, it receives a payment based on the direct costs of the education program--that is, such items as classroom space, instructors' salaries, and fringe benefits. Second, teaching hospitals' PPS payments are adjusted upward to compensate them for the indirect costs of medical education. This allowance for indirect medical education costs was introduced to cover the higher patient care costs at teaching hospitals thought to be due to such factors as increased diagnostic testing, increased number of procedures performed, higher staff ratios, and increased record keeping.

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[1] Medicare: Indirect Medical Education Payments Are Too High (GAO/HRD-89-33, Jan. 5, 1989).

[2] It is generally postulated that these patients tend to be more severely ill than other patients and require more hospital resources to treat. There is no direct measure of the number of low-income Medicare patients treated by a hospital. Rather, a hospital's share of low-income patients is determined by adding (1) the percentage of part A patient days that were attributable to patients entitled to Supplemental Security Income (the cash assistance program for the aged, blind, and disabled) and (2) the percentage of a hospital's total patient days that were attributable to patients eligible for Medicaid.

When the Congress was considering enactment of a prospective payment system for inpatient hospital services under Medicare, the Health Care Financing Administration estimated that for each increment of 0.1 in the ratio of interns and residents to beds teaching hospitals' costs increased by 5.795 percent. However, the Congress was concerned that PPS rates would not adequately compensate teaching hospitals for the higher costs associated with their being in an urban location, treating more severely ill patients, and treating a disproportionate share of low-income Medicare patients. Therefore, it decided to double HCFA's estimate so that the adjustment factor was set at 11.59 percent. The indirect medical education adjustment factor has been changed several times since 1983; current law provides a factor of 7.65 percent for fiscal years 1989-95 and 8.29 percent for later years.

Section 9202 of the Consolidated Omnibus Budget Reconciliation Act of 1985 directed us to study the variation in Medicare payments (1) among hospitals with different size teaching programs and (2) between teaching and nonteaching hospitals. We were also to account for the reasons for such differences to the extent feasible. The report we are discussing today presented the results of our study.

MOST OF THE DIFFERENCE IN HOSPITAL COSTS IS NOT RELATED TO HOSPITAL TEACHING STATUS

As the first step in our analysis, we used cost reports from 4,096 hospitals to determine the average costs and average payment per Medicare discharge. Of these hospitals, 109 were major teaching hospitals (those with an intern-to-bed ratio of at least 0.25), 525 were minor teaching hospitals (with a ratio of less than 0.25), and 3,462 were not teaching hospitals. Our analysis showed that, on average, major teaching hospitals received 106 percent more in payments per discharge and had 95 percent higher costs per discharge than did nonteaching hospitals. Minor teaching hospital's payments were 45 percent higher per discharge while their costs were 40 percent higher per discharge than were those of nonteaching hospitals.

Differences in total patient care costs among hospitals can be explained by three general factors--input prices, outputs, and efficiency. Input prices are those paid by hospitals for resources--such as labor, supplies, and utilities--consumed in providing inpatient hospital care. Output at most hospitals is the health care provided to patients. Teaching hospitals also provide graduate medical education in conjunction with patient care. Efficiency is the ability to effectively treat patients while minimizing the use of resources. The same factors that affect total hospital costs also affect Medicare costs.

Studies by GAO and others show that most of the variation in hospital costs to treat Medicare patients is explained by specific factors affecting input prices, such as location (e.g., rural, urban, central city), and specific output variables, such as the mix of patients treated ("case mix") and the presence of a graduate medical education program. Also, hospital costs are related to size (number of beds), which in turn is correlated with input prices and outputs.

We gathered data on various factors that affect hospital costs for major and minor teaching and nonteaching hospitals. As you can see from table 1, major teaching hospitals consistently show measures of these factors that indicate costs will be high, and while minor teaching hospitals do not have measures as high as major teaching hospitals, theirs are generally substantially higher than those for nonteaching hospitals. For example, the average case mix indexes of the three groups show that patients treated at major teaching hospitals would be expected on average to be about 17 percent more costly to treat than those at nonteaching hospitals and patients at minor teaching hospitals about 11 percent more costly. Also, the average wage indexes, a measure of the relative cost of labor in the hospitals' areas, show an even more dramatic difference among the hospital groups with major teaching hospitals having an average index 19 percent and minor ones 12 percent higher than nonteaching hospitals. Thus, these two factors--case mix and wages--account for much of the difference in average costs among the hospital groups and PPS rates are adjusted for these factors.

Table 1: Comparison of Specific Cost Factors by Hospital Type

Cost factors	Nonteaching (4,464)	Minor teaching (790)	Major teaching (154)
Avg. intern-to-bed ratio	.00	.08	.42
Avg. case mix index	.919	1.019	1.079
Avg. wage index	.946	1.082	1.123
Avg. number of beds	121	373	554
Avg. Medicare length of stay (days)	6.7	8.6	8.9
Urban hospitals	41%	93%	95%
Hospitals in central city of large MSA	6%	31%	53%
Discharges that were low-income patients	19%	17%	30%

In summary, it has been shown that there is a positive relationship between Medicare costs and such factors as hospital patient mix, location, and size. In addition, as can be seen from the table, there is also a positive relationship between these factors and the teaching status of hospitals. These factors, rather than the presence of a teaching program per se, help explain a large portion of the higher costs at teaching hospitals.

ESTIMATES OF RESIDUAL COST DIFFERENCES ATTRIBUTED TO INDIRECT MEDICAL EDUCATION COSTS

Our analysis concludes that after accounting for the factors discussed above, teaching hospitals still have higher costs than nonteaching hospitals. This remaining cost difference has been attributed to the indirect cost of medical education.

Given the imprecise nature of the "indirect costs" of medical education and the absence of a conventional way of measuring them, Medicare policymakers have used regression analysis as a means of adjusting PPS payment rates to reflect indirect costs. Multiple regression analysis simultaneously estimates the effect of several factors (independent variables)--such as teaching, location, and case mix--on Medicare operating cost per discharge (the dependent variable). The estimated effect of teaching on Medicare costs--and the payment adjustment factor derived from this estimate--can be smaller or larger depending on what factors are included in the analysis and how they are measured.

Using fiscal year 1985 data on 8 million Medicare discharges from 5,408 hospitals, we applied regression analysis to estimate the relationship between graduate medical education and Medicare operating cost per discharge with a number of different approaches and examined the policy implications of each. Specifically, we examined the differences in estimates obtained by

-- adjusting explicitly only for the effect of the factors currently considered in setting hospital payments and three analyses that include additional cost factors;
-- doing the analyses with and without outliers;[3] and
-- limiting the values of certain variables used in the models to their theoretical PPS payment values.[4]

Table 2 shows the cost factors considered in the four different approaches. The basic analysis (that is, model 1) used each hospital's case mix index, wage index, intern-to-bed ratio, and rural/urban location as indicated by metropolitan statistical areas (MSAs). The approach that incorporates the largest number of cost factors (model 4) added measures for disproportionate share of low-income beneficiaries, number of beds, and location in a central city. For each of the four analyses, we computed estimates by both including and excluding outlier cases for which hospitals receive extra payments from Medicare. Moreover, we also computed estimates where the values of the case mix and wages were constrained to their theoretical values.

Table 2: Factors Considered in GAO Analysis

Factor	Model 1	 2	 3	 4
Case mix	x	x	x	x
Wage index	x	x	x	x
Intern ratio	x	x	x	x
MSA	x	x	x	x
Disproportionate share		x	x	x
Beds			x	x
Central city				x

Table 3 presents the 12 estimates of the indirect effect of teaching on cost per Medicare discharge that resulted from this analysis. As you can see the estimates range from 3.73 percent for the most fully specified model not constrained by theoretical values and including outlier cases to 7.19 percent for the basic model constrained to theoretical values and without outlier cases. All of the estimates are lower than the 7.65 percent adjustment factor currently specified by law.

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[3] Outliers are cases with extremely high costs or long lengths of stay relative to average costs and lengths of stay for treating a diagnosis. Medicare makes additional payments beyond standard PPS rates for such cases.

[4] The PPS payment methodology provides prior expectations of the coefficients for the case mix index and the wage index that should be obtained in regression analysis of hospital operating costs. These prior expectations are called theoretical values. For example, under PPS a hospital's operating cost per discharge should be directly proportional to the DRG-based case mix index; that is, a 1-percent increase in the case mix index should bring about a 1-percent increase in operating cost per discharge. Thus, the coefficient for the case mix index estimated from a regression analysis of hospital operating costs theoretically should be equal to 1.

Likewise, one might expect that the coefficient for the wage index should be 0.75 because of the method used to adjust the "standard amount" for variation in wage levels under PPS. That is, the standard amount is divided into labor and a nonlabor portion, and only the labor portion is adjusted for wages. HCFA has determined that, on average, labor-related costs make up about 75 percent of inpatient hospital operating costs.

Table 3: Effect of Teaching on the Medicare Cost Per Discharge

	Estimated Effect[a]		
	Unconstrained		Constrained
Model	Without outliers	With outliers	Without outliers
1	6.06	6.51	7.19
2	5.09	5.16	6.26
3	4.10	4.05	4.36
4	3.83	3.73	4.09

[a] Percent increase in Medicare operating cost per discharge for each 10 percent increase in the intern-to-bed ratio.

SELECTING AN INDIRECT MEDICAL EDUCATION ADJUSTMENT FACTOR

Selecting among these 12 estimates the 1 to be used as an adjustment factor for PPS is a policy choice. However, the choice made affects all hospitals, not just teaching hospitals. Because under PPS the total amount paid to hospitals remains the same when adjustments are made for particular hospitals or groups of hospitals, paying more to teaching hospitals results in paying less to nonteaching hospitals.

We recommended in our report that the Congress reduce the teaching adjustment factor for 1989 and beyond. We concluded that our estimate of 5.09 percent represents the best option for determining the additional payments to teaching hospitals for fiscal years 1990-95. Our reasons for this conclusion are fully explained in the report, and I will only highlight them here. This estimate considers essentially the same factors that will be used to determine PPS rates during the period and is generally free from the influence of other issues affecting these rates. First, the estimate does not include the effect of outlier cases, which involve extremely high costs or long lengths of stay. Including outliers would compensate teaching hospitals more equitably for such cases, but equity would not be improved for other hospitals with outlier cases. We believe it is preferable that any shortcomings in outlier payment policy be addressed by revising that policy so that all hospitals are treated equally.

Second, the estimate was computed without limiting case mix and wages to their theoretical values. If these factors are limited, teaching hospitals would be compensated for potential shortcomings in the current PPS payment rates related to the two factors, but other hospitals would not. Again, we believe it is preferable to address any shortcomings directly by modifying case mix and wage index policies so that all hospitals benefit.

If the indirect medical education adjustment factor used the 5.09-percent estimate, payments to teaching hospitals would be reduced by $808 million in fiscal year 1990, $991 million in fiscal year 1991, and $1.1 billion in fiscal year 1992. If the Congress decides to reduce the adjustment factor, as we believe it should, and if the Congress wants to use the reduced payments to teaching hospitals to lower overall Medicare outlays, the legislation would have to specifically reflect that decision. Otherwise, under current law the reduction for teaching hospitals would be offset by increases in payments to nonteaching hospitals.

Chairman STARK. Mike, I think we'll hear from the rest of the panel first. But, I did want to ask if the same statistician who numbered the models on the first chart, numbered them on the second chart? [Laughter.]

I hope he didn't. [Laughter.]

Dr. Thorpe.

STATEMENT OF KENNETH E. THORPE, PH.D., DIRECTOR, PROGRAM ON HEALTH CARE FINANCING AND INSURANCE, HARVARD UNIVERSITY, SCHOOL OF PUBLIC HEALTH

Mr. THORPE. Thank you, Mr. Chairman. My name is Ken Thorpe. I'm director of Harvard's program on health care financing and insurance and I'd like to focus two particular subjects.

First, I'd like to highlight what I believe is a major problem with the current method of both of determining and setting the indirect payment methodology. And, second, I can't help but—given the opportunity—to suggest some alternative methods of determining the adjustment.

I'd like to focus on four problems that I've identified with the methodology of setting the indirect payment rates.

First, the statistical estimates that generate the indirect adjustments are somewhat arbitrary. Second, the adjustment results in less than equitable payments across teaching hospitals. Third, it's confusing, not easy to understand. I think that there's a presumption that it pays for medical education when, in fact, it pays for a variety of things that affect the costs of teaching hospitals, which are unrelated to medical education. And, fourth, it's a formula driven system that's passive, in the sense that it doesn't give Medicare much control over the distribution of the dollars.

As you've heard, we currently pay approximately a 7.65-percent addon for each 0.1 increase in the resident-to-bed ratio. I think the history of how we come this figure is somewhat instructive.

There's really a three part process.

First, a statistical estimate is developed of what the indirect adjustment should be. Second, simulate the effect of the adjustment on payment to teaching hospitals. Inevitably, given the methodology that's used, we see that teaching hospitals will lose. Third, as a result, we add a policy multiplier.

So, in fact, the adjustment is based on average teaching hospital costs which has some tangential relationship to the statistically generated numbers.

You've heard some proposals which say that the current adjustment is too high. That is should be limited to 4.05 percent, or that it should be retained at its existing levels. Let me go on and talk more specifically about the four problems with the adjustment previously noted. This would give you some feeling about, some guidance perhaps, concerning what level the rate should be set.

First—let's focus on the first problem. Based on some work I've also completed using the Medicare data sets, I could generate statistical estimates of the indirect teaching costs of 3 percent, 9 percent, 6 percent, whatever I want it to be. It really depends on the decisions the researcher makes, in terms of how the model is specified.

I think, as I mentioned, that that's somewhat arbitrary. It's inaccurate. And, I think that as policymakers have recognized, through the addition of this policy multiplier, that they've also recognized that this is an inadequate methodology.

Second, the current methods used to measure ongoing cost differences among teaching hospitals is also inaccurate. Notably, the statistical interpretation of the log of the resident-to-bed ratio is not correct. It's inaccurately interpreted. We'll likely overpay smaller hospitals vis-a-vis larger teaching hospitals.

Another problem with the methodology, is that there's a mismatch between the statistical estimate and the payment policy. Statistically, this is based on total residents divided by total beds in the facility. And, as you know, the payment policy is based on inpatient allocations of residents divided by nonexempt unit beds. So, even the statistical and payment methodologies don't match up.

A fourth problem is that, I know a major goal of the PPS system was that it was supposed to be something that was easy to understand. I think that the current method, by any measure of determining the indirect adjustment, is obscure. It's not clear what's being paid for, what elements of teaching costs are being reimbursed, and I think that the methodology used also fails on that count.

So what are we left with? We're essentially left with the same process. We have two estimates on the table that say it should be 4 percent, or according to ProPAC's analysis 6.6 percent.

In either case, you could generate the statistical estimates to justify either adjustments. If you pick the 4 percent adjustment, that means that you're going to reduce per case payment to large teaching hospitals by about 9 percent. To smaller teaching hospitals, by about 3 percent. Should you pick the ProPAC adjustments, you're going to reduce payments to large teaching hospitals by about 2.6 percent, and the smaller ones by about 0.7 percent.

I think the issue here is that the reductions, should there be some, should not be statistically driven, but rather should be policy driven. And, in that sense, requires a much broader examination of how the distribution of the savings would be generated through the hospital system.

Let me just, at this point, give you one idea of how perhaps to look at this. By its very nature Medicare, when it uses a pricing system, creates winners and losers. That is, it substantially overpays other hospitals, and substantially underpays other hospitals, relative to their average costs.

One proposal would be to do something that New York State has done on the nursing home side. Which would be to limit the extent to which the winners, under this system, would be winners. Use some percentage above their average costs. You could then take the residual payments from that and use those, if you will, for savings.

We've already seen, in some of the research literature, that overpaying hospitals is dysfunctional since those hospitals have higher cost growth. At other hospitals, I think that there's a real policy issue about why continue to overpay certain hospitals, relative to their costs.

Let me focus quickly on a proposed alternative. One way then to look at the savings, is to look at a broader examination of PPS payment policy. The proposal that I would make is quite simple.

First of all, I would drop the current way that the indirect adjustment is made, that is, through a statistically driven method. As I mentioned, I think it's arbitrary. And, I think it's not clear what we pay for. It doesn't accurately reflect the variation in costs among teaching hospitals. And, again, there's no control over the distribution of payments.

A much easier way, is to approach the subject the way that a lot of other States have done on the non-Medicare side. Large teaching States, such as Massachusetts, New York, and New Jersey, may often set separate payment rates for major/minor teaching hospitals.

It's very similar to the way that you set payment rates for urban hospitals, and rural hospitals, under PPS. So, in that way you have a PPS precedent. You also have precedent, and a very successful one, in both New York and New Jersey.

I think the advantages of that are multiple.

One, is that it's not subject to some of the esoteric worlds of statistical analysis and regression analysis. And, it would keep some of us economists out of the policy debate, in terms of what the payment levels should be. It's based on actual costs, which in essence is what you do now anyway. We currently use both a policy multiplier and the statistical estimate—in essence are basing it on actual teaching costs, anyway.

I mentioned New York and New Jersey as precedents. I believe their methodology provides a much more accurate characterization, and measure, of costs variations within large and small teaching hospitals.

Thank you, Mr. Chairman, for inviting me to testify here, and I applaud you in addressing and grappling with this very difficult issue.

[The statement of Mr. Thorpe follows:]

STATEMENT OF KENNETH E. THORPE, HARVARD UNIVERSITY SCHOOL OF PUBLIC HEALTH

I. Introduction

Payments received by hospitals under Medicare's prospective payment system (PPS) are determined by two factors: the cost weight associated with a Medicare patient's discharge diagnosis (DRG) and the hospital's standardized payment rate. Since average operating costs per discharge are 75 percent higher in large teaching hospitals (mainly those who are members of the Council of Teaching Hospitals (COTH), some method of recognizing these large cost differences are required (see Table 1). Methods used by the Health Care Financing Administration (HCFA) to account for the substantial variation in hospital costs have been actively debated since the introduction of PPS in fiscal year 1983. The standardization process is HCFA's attempt to account for legitimate cost differences across hospitals. Determinants of cost selected by HCFA include the hospital's DRG case-mix, a wage index, an adjustment for the volume of low-income patients and an adjustment for a hospital's teaching status. The latter adjustment is measured using a hospital's ratio of interns and residents to beds. Finally, payment rates are calculated separately for urban and rural hospitals.

HCFA's adjustment for the so-called indirect costs of medical education has been a subject of controversy since the inception of the PPS program. Unlike other elements of the payment system (except the disproportionate share adjustment) the adjustment is based on a regression analysis. The original adjustment was based on a regression coefficient from a cost function developed by Pettengill and Vertrees (1982).[1] Included in their model was each hospital's case-mix, a wage index, three city size indicators, hospital beds, and the resident to bed ratio (plus 1). In practice, the actual adjustment made to teaching hospitals under PPS has never been based exactly on the regression results. Since the regression included variables (which were positively related to teaching status and costs) not recognized in HCFA's payment formula, implementation of the "technically" derived adjustment would have disadvantaged large teaching hospitals. As a result, the statistical estimate was originally doubled. Subsequent estimates of the indirect teaching adjustment have also been modified by an additional multiplier.

Recent studies suggest the existing adjustment (approximately a 7.65 percent add-on for each 0.1 increase in a hospital's resident to bed ratio) is too high. In general, these conclusions are again based on statistical analyses similar to those originally completed by Pettengill and Vertrees. These studies have identified and corrected number of econometric errors in the original estimation model. As I will point out, however, these "technical" adjustments constitute major changes in payment policy toward teaching hospitals.

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[1] J. Pettengill and J. Vertrees, "Reliability and Validity in Hospital Case-Mix Measurement" Health Care Financing Review. 4 December 1982: 101-128.

More recent estimates of the indirect teaching add-on have demonstrated that the statistically estimated adjustment is very sensitive to methods used by researchers completing the analysis. Through my own simulations, I have demonstrated that what has been coined the "indirect" costs of teaching could range from a 3.15 percent to a 7.16 percent add-on. Thus, unlike other aspects of the PPS, the payment levels to teaching hospitals depend both on statistical modelling decisions made by researchers as well as input from policymakers. Hence, far from an objective or even accurate "black box," the regression approach to determine payment rates to teaching hospitals implicitly involves policy judgments by researchers. As I will discuss below, modelling decisions made by researchers to estimate the teaching add-on may alter the basic definition of the indirect teaching costs. Thus, the nature of these policy judgments should be understood before decisions regarding proposed adjustments to the indirect add-on are implemented.

Specifically, the sensitivity of the statistical estimates of the indirect teaching to modelling decisions made by researchers raise at least two important public policy issues. First, refinements in the methods used by researchers to estimate the indirect teaching costs transcend simple statistical importance and represent major changes in HCFA payment policies toward teaching hospitals. Second, the tremendous variation in the statistical estimates of the indirect teaching adjustment requires broader discussion concerning the methods used to determine future payment levels to teaching hospitals.

II. Historical Versus Proposed Definition of the Indirect Teaching Adjustment

In practice, the indirect costs of graduate training have been defined empirically. They generally represent all remaining costs between teaching and non-teaching hospitals after controlling for certain variables. For instance, after adjusting for case-mix, and wages (and subsequently share of low-income patients treated) costs in large teaching hospitals (those with four or more major residency programs) remain approximately 25 percent higher than non-teaching hospitals. In some studies, this residual is coined the "indirect" costs of graduate training. A variety of factors likely account for these higher (indirect) costs including differences in mix of services provided, a more technically skilled mix of labor, more severely ill patients, and a more aggressive style of practice performed by attending physicians and their residents among others. Researchers accounting for these other factors in their studies generate lower estimates of the indirect costs. It should be noted, however, that this changes the definition of indirect teaching costs, making cross-study comparisons of its magnitude difficult.

Originally, the HCFA researchers defined the indirect costs of graduate medical education as all remaining cost differences between teaching and non-teaching hospitals after accounting for case-mix, wages, bed size, and city size. However, since the PPS payment formula did not account for city size or beds, simulations revealed the estimated adjustments would generate substantial losses for teaching hospitals. As a result, it was subsequently doubled. Combining the statistical estimate with a "policy" multiplier provided (at best) only a tentative understanding of the nature of the costs implicitly recognized under the adjustment. As a result, since its inception, factors accounting for the indirect teaching adjustment have never been well understood.

Subsequent to the original statistical analysis performed by the HCFA researchers, a variety of econometric shortcomings with the model were identified. Perhaps of most importance, the original model excluded a variety of relevant variables known to influence Medicare costs. In general, these variables were positively correlated with both Medicare operating costs and teaching status. Thus, the inclusion of a more expansive set of variables in subsequent analyses lowered the estimated relationship between teaching status and costs. As mentioned above, my estimates of the indirect costs range from a 3 percent to over a 7 percent add-on. Thus, changes in the models used to estimate the indirect adjustment not only represent statistical or technical adjustments, but more important they alter the definition of indirect teaching costs. In effect, more recent estimates "pass through" fewer factors accounting for the residual cost differences between teaching and non-teaching hospitals historically recognized in the PPS payment system.

III. How Should the Indirect Teaching Adjustment Be Determined?

Assuming a statistical adjustment for teaching hospitals is retained, four options are available. First, the adjustment could be determined using the same methodology and specification used in the original HCFA analysis. Second, the regression analysis could include only those variables actually used in the PPS payment formula. Third, new, more complete statistical estimates could be completed correcting for the remaining econometric errors in the models, thus basing the adjustment on a more accurate methodology. Finally, the indirect adjustment could be entirely eliminated, with payments for "teaching" hospitals determined using a methodology similar to that now used to set payment rates for urban and rural hospitals under PPS. Whatever method is selected, it seems important that future reforms of the adjustment are based on a consistent methodology. In this manner, subsequent statistical estimates of the indirect adjustment will not be confused with policy changes implicit in different statistical methods employed by policy researchers. I will comment briefly on each of these alternatives below.

A. Use the original model specification.

Use of the original methods employed by Pettengill and Vertrees in determining the indirect adjustment would not alter the underlying definition of the indirect teaching adjustment. Under this approach, the indirect add-on represents the product of the statistical estimate and a "policy" multiplier. Thus, changes in the indirect add-on could be made through either component. The downside of this approach is that the precise factors accounting for the higher costs of teaching hospitals recognized in the indirect adjustment will not be known. Whether policymakers want to identify the factors leading to higher costs, and decide which ones to explicitly include in the indirect adjustment, remains an outstanding issue.

B. Use only the payment variables in the regression.

Restricting the regression to the PPS payment variables would recognize all factors accounting for higher costs in teaching hospitals other than case mix, wages, share of low income patients, and urban/rural location. Thus, the statistical estimate could be used without the addition of the "policy" multiplier used in Option A. Determination of whether payment rates are "too high" or "low" would be based on periodic re-estimations of the cost function using only the PPS payment variables. According to my recent estimates, the indirect add-on using Option A or B would, at a minimum, be set at 7 percent for each 0.1 increase in the resident to bed ratio.

C. Correct the current methodology for econometric errors.

From a statistical (as opposed to a public policy) standpoint, the current method of estimating the indirect teaching adjustment suffers from a number of methodological shortcomings. First, current methods used to measure teaching "intensity" result in biased estimates of the relationship between costs and teaching status. Previous analyses have used the log of the resident to bed ratio plus 1. The estimated coefficient on the resident to bed ratio is interpreted either as an elasticity or as the percentage increase in costs for each .1 increase in the resident to bed ratio. Neither interpretation is correct. Adding one to the resident to bed ratio is a very large number relative to the underlying values of this variable. For instance, an increase in the ratio from .2 to .3 is a 50 percent increase, but only an 8.3 percent increase in the variable plus one. Thus, the coefficient estimate is not an estimate of the elasticity of interest. This method results in a significant overestimate of the indirect costs, especially for smaller teaching programs. As a result, a different measure for teaching intensity is required. One suggestion is to allow for separate estimates for different classes of teaching hospitals (e.g. major, minor, and affiliated hospitals). Indeed, previous research indicates the current constant elasticity measure is not the appropriate specification of the teaching variable.

Second, current regression models exclude a variety of relevant variables from the model. For instance, measures of service mix (e.g. burn units, ICU/CCU units), physician staffing levels, occupancy rates, and number of discharges are routinely excluded. Including these variables provides a more accurate model; however, lower estimates of the indirect teaching costs will result. Although the more inclusive model is statistically correct, its policy relevance is unclear. On the other hand, more expansive models would allow a better understanding of the nature of the costs implicitly passed-through under the indirect teaching adjustment.

D. Eliminate the Indirect Teaching Subsidy

A final option is to eliminate the indirect adjustment, and determine separate payment rates for teaching and non-teaching hospitals. Using separate teaching and non-teaching groups to determine payment rates would eliminate the need for the statistically defined adjustment. The PPS already has a precedent for this approach with its calculation of separate urban/rural rates. In addition, New York State and New Jersey have used similar approaches for determining payments to teaching hospitals under their DRG payment systems. Although this approach requires policymakers to define a "teaching" hospital, experience from the two states noted above indicate the problem is not intractable.

Conclusion

Whatever approach is ultimately used to determine Medicare's level of support for teaching hospitals, it is important to recognize the policy judgments inherent in the decision. In addition, use of a consistent methodology will provide a more equitable basis for setting payment levels for teaching hospitals. As I have discussed above, various statistical approaches yield dramatically different estimates of the "appropriate" adjustment for teaching hospitals. Thus, an assessment of whether the current adjustment is "too high or too low" cannot rely on a purely technical approach, and must address a broader range of PPS payment policy objectives concerning the future mission of graduate medical education and teaching hospitals.

Chairman **Stark**. I thank the witnesses. I've been afraid that someday I would have to confess to what really goes on around here. Because there is a rather complicated, and scientific, procedure that the subcommittee goes through in deciding how we will deal with practical medical education.

It starts with a regression analysis of the price, value, and ratio of Humana stock. [Laughter.]

Then we proceed to contact the AMA's ethicist, Dr. Claus von Bulow, for his input into the formula.

I talk to Harlem Hospital, in Oakland, CA, and ask them how they're coming on the control of assault weapons. Which will have something to do with the trauma care units—and how we're doing there.

And then, I call Sister Sheila at Mercy Hospital and say "how much do you need Sister?" [Laughter.]

We put that all in a bottle and shake it up. And, then I call Mr. Pickle to make sure that the rural hospitals are taken care of and whatever we have left when we're done with Mr. Diamond is what teaching hospitals get.

Now, if there can be anything more scientific and statistically accurate than that, I know not what it is. But, what troubles me is how close we must be. If, in fact, you look at your chart—and say, wait a minute, there's 154 major teaching hospitals, and that's not to denigrate the smaller ones. Arguably eight of them are rural.

By your statistics, 74 are in inner cities and 72 are suburban. My guess is that the inner-city hospitals, if you want to take a guess, are handling half the low-income discharges. If you split up that last figure, more of the low-income discharges.

Quite seriously, we have used the budget and medical education adjustment as a way to compensate for what we think is a failure in uncompensated care.

When you play these games, and several of you are realistically suggesting that we shouldn't, you really do lose sight of what we're talking about. I'm entirely serious when I say that I don't know why we get into this.

I'm concerned about the 154 hospitals that are teaching, and the 790 minor teaching hospitals. But, that isn't such a huge number of hospitals that we can't take them almost a case at a time, and not have to have all of you defending the statistical basis.

Because when you all get done, it lands up on our desks driven by some unforeseen figure that will be handed to us by the budget committee. Then we divvy up a whole host of requests.

Sooner or later, when we get some kind of uniform reporting, we will be able to take the expertise that you bring to this committee and do a lot more with it. We could have real fine sessions with the actual costs and income factors of these hospitals, and have a better idea of what we're doing.

We are, in spite of, and indeed—with the use of all the expertise you bring here, we're still shooting in the dark. Then, we end up coming out with a reconciliation package. I hope that's not an affront to your professional approach because we do appreciate what you bring to us.

It's a vexing problem, and I know you guys know what we do here. I don't know from whom we're defending our decisions. Or to what audience we're looking for support, but it's gotten to be rather a shell game.

I would hope that we could find ways to make some better definition of what we ought to pay. We've heard all kinds of testimony here this morning, and I don't know quite how to solve it.

I'm sure that this year we will just have a repeat of what we've had the last couple of years. We're going to be faced with more cuts than we want to make in the system. It isn't going to be a question of whether this committee will be able to help anybody very generously. It's who we're going to hurt the least.

That's not a whole lot of fun. It's probably not much more fun than having your hard work, which might lead us into a more generous climate to be able to do a better job. On the one hand don't despair, your day will come. Keep that guy who gets from one to three/five on your staff. [Laughter.]

He at least, or she, as the case may be, brings a little bit of life into the committee.

Thank you very much. Mr. Levin.

Mr. Levin. Well, is there anything to say after that? [Laughter.]

Chairman Stark. I didn't mean to give away your secrets.

Mr. Levin. I'm not going to say whom I called. I think that the chairman's asking this question. You know the data as well as, or better, than we do.

Why should we take, Mr. Zimmerman, your figures and a difference of one point or one/three, whatever it is, and hurt hospitals that other data would seem to indicate in many cases are in trouble? Unsure that we can make up for the loss revenue of some other place? I think that's what we ask ourselves.

They're not all in trouble, but some of them are in large urban centers. We not only know that they're under immense pressure now, but that those pressures are going to increase. If you were sitting on this side, instead of there, how would you answer that question?

Mr. Dowdal. One thing that I always try to keep in mind, as we said several times in the statement, is that, when you give it to one hospital you're taking it away from another. That is the way PPS has worked since the day it was enacted.

I don't foresee that that's going to change. If you're going to give more to teaching hospitals, you're going to be giving less to community hospitals. And, vice versa. If you give more to one you're going to take it away from the others. Because we've had this zero sum game.

It makes your problems even more complicated because you can't help somebody without hurting somebody else.

Mr. Levin. Then the dilemma is even worse, because the data seem to indicate that some of the teaching hospitals are doing all right, but others are doing poorly.

Mr. Zimmerman. I think as a class they're doing better than other groups of hospitals.

Mr. Levin. But the larger ones are doing worse.

Mr. Zimmerman. I don't know. I think some very large teaching hospitals are probably doing quite OK. Well, it's where they're located and what their case mixes are like.

Mr. LEVIN. The Prospective Payment and Assessment Commission, and you've seen this, maybe these figures are wrong. But, I think we do look at these kind of bottom line figures.

They show, in terms of the margins, this is 1987 data, that teaching hospitals are doing slightly better than nonteaching hospitals, as you say. But, major teaching hospitals are doing considerably worse than other teaching hospitals.

So we have this disequilibrium.

If we just take your approach, the conclusion, and just apply it across the board, we're going to end up affecting the best off and the worst off. That seems to be a very high price to pay. Especially, since the indicators seem to point that those that are now worse off, will still be worse off a year from now.

The health needs, the impacts, are going to become more serious, not less so. I don't know what we do. Even if we accepted—if you came back with a huge differential, instead of a point or two, maybe it would force us to do something.

How do you approach it? Change places for a moment.

Mr. DOWDAL. Well, it's not a very easy question to answer as I don't have to make that decision. But, that's what it is. It comes down to a decision that you have to make, how are we going to do this? How are we going to try to make sure that teaching hospitals are getting adequately compensated, but not overly so at the expense of other hospitals?

In our judgment, after we looked at all the numbers that we had, the different kinds of models, and you get into all those, we've tried to be very forthright in stating in the report all of the things that get involved in all that. We chose 5.09 percent, out of those estimates. We thought that the 5.09 percent one would be the best based on current law.

The way that it's being done that estimate would be the one that most closely reflects the actual difference in costs that is incurred by teaching hospitals. We felt that would be the fairest way under the scheme that the law currently sets forth for paying for these kinds of hospitals.

Mr. LEVIN. OK. Our dilemma is that——

Mr. DOWDAL. That was our's too——

Mr. ZIMMERMAN. We also pointed out, Mr. Levin, that there are some deficiencies that relate to outliers and case mix indexes, and wage indexes, that should be addressed. So, it's more of a combined effort——

Mr. LEVIN. Right, right——

Mr. ZIMMERMAN. But you can't ignore those other things.

Mr. LEVIN. And I saw that. You said that in two instances. I just don't know how we do that.

Mr. DOWDAL. There's also one other point. Last year we issued another report. A lot of the doctors who testified here earlier, they were talking about the intensity factors used by Medicare not being good enough.

Well, last year we issued a report specifically recommending one way that that could be better adjusted for by more accurately grouping cases into the diagnosis related groups. I believe that Yale has come up with some proposals along that line. Now, that's another thing that would help all hospitals. We've kind of been looking at it from the standpoint of how can we assure equity for all hospitals.

Mr. LEVIN. I don't think we're hesitant to make major moves, and, in fact, I think major moves are necessary. But, we want to be sure that it helps more than it hurts. There are such disequilibriums here.

I mean, it's alright for you to say—well there are these two other—there outliers and all that, and you should take care of them directly some other way. I don't see the way to do that.

I would be willing to make some hard decisions. Even among hospitals, say, in the Detroit metropolitan area. I'd be willing to hit those with higher margins, in terms of teaching functions. As long as I'm not hitting the tight ones and I know they're going to become worse. I'm not using the fact that there are some tight, to protect those that aren't. You don't propose, and no one's proposed, a way to change this without a really deleterious effect on hospitals that you, I think more than anybody else, would say simply cannot withstand added pressures. Indeed, need some alleviation, whether it's in New York, Los Angeles, or Detroit, or whatever.

Chairman STARK. Mr. Pickle.

Mr. PICKLE. Mr. Chairman, I don't have a question. I just want to say to Mr. Zimmerman that one of the major teaching schools in my State contends to me that, under the present system, they're just breaking even, just making it.

Now if you come in and reduce them, from 7 down to 4, or even 5, you almost put them out of business. Now you don't intend to do that. You talk of special measures to give a little more to some hospitals, but then you've got to give less to others.

Of course, that's true. But you're not recommending we make them all the same. You just make the general observation, and that's not enough. My school is making a study now, and I understand there are others by some professional groups to determine a fair division of the cents/costs analysis, why these costs are this high and they stay in line.

I'll just listen to their judgment, they're an outside group. I think it's appropriate that they're doing that. I'm going to look at those figures. I'm going to look at your charts up there. They may ask you to go in there and do a little studying yourself at the school. But, I'm not going to be in favor of reducing these fees when they're just breaking even. It's one thing to say we've got to save some money, but we've got a little inaccuracy.

What I don't understand is why the facility in my State is just breaking even and the other teaching schools might be coming out ahead or little behind? Just because there's an inequity, or a difference rated, doesn't mean I want to reduce payments until I have some other facts. I think we need some more facts on this one.

Chairman STARK. If the gentleman would yield on that, and in answer to part of Mr. Levin's dilemma.

It would be my guess, and I'd ask the witnesses that if, in fact, we had a uniform reporting system if not uniform accounting system, in place; if we had a severity index—and I think you alluded to a new DRG shortage system—we could measure that. And, a cost input factor. Not index, not the costs which are subject to management choices. But, if we had an index on the cost of beef.

Each hospital could decide how much beef they're going to give each patient.

If we had a cost input index, somewhat more accuracy in our wage index, the severity index, and in the form of reporting, I have a hunch with that small number of hospitals we could zero in and stop playing this average game. We could practically zero in on a hospital specific basis to do this.

I think we're very close. I hate to keep stumping for my idea of uniform reporting. But, it would help us to know. Sometimes we want to know, Jake, and sometimes we don't want to know, depending on whether it helps or hurts. But, I guess that we've played this game with ourselves and with OMB long enough. I figure we may as well have the specific numbers.

And, then I can compare Oakland's hospital to Austin's hospital to Detroit's hospital, and we can sit down and hammer out a deal. We will be more sure that we know what we're doing. And, I think you guys would be more comfortable coming here.

Mr. ZIMMERMAN. I do.

Chairman STARK. What else do we need besides those? I mean, aren't those the major inaccuracies that we're faced with at this point?

Mr. THORPE. Those are two of them, if I may comment. Those are clearly two of them. There's clearly unmeasured severity amongst those difference. On the input price side there's some variation there that you can improve on.

Much of it though, I think, is really related to differences in the capital stock and the technologies of the institutions, the attendant ancillary personnel, and staffing ratios at these hospitals. For example, if you compare teaching hospitals in Boston to New York city even, which are very similar——

Chairman STARK. But those are things that are pure management decisions. If they were to be used as some kind of prospective payment, that's where we've got to say let the devil take the hindmost.

Mr. THORPE. Unfortunately, I mean——

Chairman STARK. I mean, that we can never change.

Mr. THORPE. I agree with you. It's a management decision. I guess the issue is that it's technology that's in place. I mean it's things to a large extent——

Chairman STARK. So we can't do it overnight. I suspect that cost reimbursement has, in the past, driven a lot of the decisions except—say, in New York State, where good cost controls have prevented perhaps adequate capital investment. I'm not suggesting this could happen like that. But, if we're ever going to approach a horizon of reality we ought to have these things.

I keep thinking we are very close to having a fairly scientific way to divvy the funds up—and, we'll know who we're hurting and who we're helping with some specificity. I hope we can encourage our colleagues to say uniform reporting isn't punishing hospitals. It ought to help them, in the long run. We, on the other hand, have some obligation to push for somewhat more—severity is tough. That's very technical for us to deal with.

Cost input, as distinct from historic cost practices, would be helpful too. One of these days we'll be able to do this in your ballpark.

The scientific way, rather than the politic way. Look forward to doing it then.

Mr. Levin has agreed, I want to thank this panel. Very much. Will there be a vote?

Mr. Levin. No vote.

Chairman Stark. No vote? Happy to turn the gavel——

Mr. Levin. You never know——

Chairman Stark. Back to my distinguished colleague.

Mr. Levin. Well, thank you——

Chairman Stark. Thank you.

Mr. Levin. I guess you're the last panel. We're not sure about a vote. We don't think so, but maybe we can move along quickly, in any event.

Dr. Buchanan is next. As always, we regret the movements in and out. Maybe I'll just sit over here. In each case staff is here. The last panel is always the most difficult one. Staff is here taking notes.

It's interesting. I think we've had a very useful discussion. I hope you've thought the same. If I might say so, on my behalf, the more you can comment on what has transpired so far, the better.

So, Dr. Buchanan you're here with—why don't you introduce who's here.

STATEMENT OF J. ROBERT BUCHANAN, M.D., GENERAL DIRECTOR, MASSACHUSETTS GENERAL HOSPITAL, ON BEHALF OF THE COALITION OF BOSTON TEACHING HOSPITALS AND THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES, ACCOMPANIED BY RICHARD M. KNAPP, PH.D., SENIOR VICE PRESIDENT, ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Dr. Buchanan. Thank you for the opportunity to appear before the subcommittee to address proposed reductions in Medicare funding for the indirect medical education adjustment. I am J. Robert Buchanan, M.D., general director of the Massachusetts General Hospital, and formerly dean of the Cornell University Medical College in New York.

My testimony is given on behalf of the Coalition of Boston Teaching Hospitals, whose membership includes the Beth Israel Hospital, New England Deaconess Hospital, Brigham & Women's Hospital, New England Medical Center, the University Hospital, Carney Hospital, and the Massachusetts General Hospital. All of these hospitals are members of the Council of Teaching Hospitals of the AAMC, and I am joined on my right by Dr. Richard Knapp, senior vice president of that organization, who will have a few additional comments to make.

My purpose today is to try to provide you with some facts about the current fragile status of the institutional members of our coalition, with the hope of assisting you in making the difficult choices associated with meeting budgetary requirements and valued social goals.

To that end, I would like to make three initial points:

The group of seven teaching hospitals I represent are all losing money, not making money, on Medicare patients and on operations overall. While Medicare costs in these seven hospitals are increasing at rates commensurate with the increased costs we have to pay for goods and services, Medicare revenues have increased negligibly over the last 4 years and are now significantly below our costs of providing services to the elderly.

The proposed reductions in the indirect medical education adjustment and in the direct medical education adjustment, combined with other proposed reductions in Medicare reimbursement, would impose an awesome financial burden on these institutions and threaten their ability to provide essential services.

We have submitted extensive testimony, Mr. Chairman. I would like to simply walk through the exhibits and make a few explanatory and extending remarks. I would like first of all to say, however, that the data in those tables A through I are from the audited books of our coalition member hospitals, from their cost reports, from their board-approved budgets, and from their 1989 year to date operating statements. They have been assembled by Coopers & Lybrand, and that firm is prepared to certify those statements.

In exhibit A, you will see that we operate just under 4,000 beds, and have about 22,000 employees. This represents 20 percent of all hospital employees in the Commonwealth, and about 5 percent of the Boston work force. We have 150,000 discharges a year, and about 1,600,000 outpatient visits.

We are operating about 82 percent of our licensed beds. If we excluded unstaffed beds, we are operating at 88.2 percent occupancy, and it is not an infrequent occasion that we have to close our emergency rooms and divert the ambulances because we are unable to accommodate acutely ill patients requiring our acute care units.

We have about 1,500 young people in training as residents, and I should point out that in this recent match for the first-year resident positions, there was further evidence of a declining interest on the part of young people in many of the specialties in this morning's discussion as most needed by our society at the present time. So, clearly we have a major challenge to make those specialties more attractive to young people who are now opting to go elsewhere.

It is very interesting that in a discussion we had at Mass General within the last 10 days, it is very clear, based on anecdote, they appear to be moving into the very technically oriented specialties which, coincidentally, do happen to pay more.

Mr. LEVIN. Have you thought about what in the Boston area you might do about that?

Dr. BUCHANAN. We have, to be honest with you, within our medical center extremely little ability to move that around. In the discussion this morning, graduate medical education was framed as something which was a medical school responsibility. The reality is that the medical schools do not have very much direct control over graduate medical education, and indeed, the hospitals have less than many people think. It is largely in the hands of extramural specialty organizations and boards, which determine the number of trainees many of us are allowed to have. So, it is a matter of the chiefs of service-filling quotas that are allocated to them by extramural accrediting agencies.

Our research is significant, $245 million, but I think the most important thing is that we are really the first line of defense when it comes to access, aging, AIDS, and abuse of people and substances. We operate burn units, trauma units, neonatal units, and in addition to all the high technology, we are major providers of primary care through the neighborhood health centers, which every one of the coalition members operate.

At the General alone, we are the primary care physician for no less than 150,000 people in the immediate environments of our institution and our neighborhood health centers, of which we operate three. And, of course, we accept referrals from all over the city, the region, the country, and indeed, the international arena.

If we look at exhibit B, based on charges, you will see what kind of payor utilization we have. We are about 35.5 percent Medicare, 9 percent Medicaid, and 5.1 percent indigent—that is individuals who cannot pay, and for whom there is no third party payor.

The total uncompensated care these seven hospitals give is about $133 million, of $392 million given in the Commonwealth, or about 34 percent. It happens that the Boston City Hospital is included in that figure. We were unable to exclude it. If you took it out, the percentage provided by these hospitals would in fact increase.

In exhibit C, you can see what has happened. We have had a major growth in discharges. In the 4-year period, the increase has been 9.1 percent, or an annual compounded rate of 21.9 percent. Operating revenues have increased by 27.5 percent. Total operating expense has increased by 31.9 percent, and our operating margin has gone from a positive 1.87 to a negative 5.95.

This is compared in exhibit C–1 with the data from national sources relating to the hospitals nationally. In exhibit D, we are talking now about total payments from Medicare to these seven hospitals. You will see that in the period from 1986 to 1989, there has been a 5.8-percent total growth in the Medicare reimbursement. Total Medicare expenses at the same time have increased by 8.4 percent in 1 year, or 34.2 percent in that 4-year period.

The Medicare gain has gone from a plus $59 million to a minus $37 million, and the Medicare margin has gone from a plus 14.5 percent to a negative 8.5 percent.

If you look at exhibit E, you will see what has happened with respect to Medicare inpatient payments. Here, in the interest of time, I would simply point to the cost per case mix adjusted discharge—that is what CMAD means, about two-thirds of the way down the page. You will notice that has increased by 21.8 percent over a 4-year period, but within that 4-year period, starting in 1987, that cost has increased at a much slower rate. It was increased in 1987 over 1986 by 10.5 percent; in 1988 over 1987, 5.5 percent, and it is budgeted in 1989 at a 4.5-percent increase over 1988.

That is due to two factors, we believe. One is an increase in the volume, and the other are major efforts at cost containment which are ongoing in our membership. You will see that the Medicare inpatient margin has gone from a plus $66 million to a minus $21 million, and the percentage of margin from a plus 18 to a minus of 5.8. This is demonstrated in graphic form in exhibit F.

In exhibit G, you will see what has happened to our PPS margins, and here again we have gone from a positive 23.1 million to a projected 4.3 million negative this year. If you were to add the proposed reduction of the indirect medical education adjustment to 4.05, the PPS margin would be a minus 13.9 percent.

Mr. Levin. Let us see, how much of the overall budget comes from the indirect and the direct? Can you tell that from here?

Dr. Buchanan. Well, if you go to exhibit H, you will see that the cut from 7.7 to 4.05 would represent a reduction of almost $30 million in the aggregate to those seven hospitals, which is just under the projected total Medicare operating loss for 1989.

We have a proposed capital payment reduction to 75 percent. You can see that would cost us another $3 million. And if the inflation update were assumed to be 2 percent, it would cost us another $8.5 million, so that the projected loss overall would increase to $78.4 million for these seven hospitals.

Mr. Levin. What are you going to do, with this kind of shift toward an operating loss?

Dr. Buchanan. Within the last several months, we have already reduced in our institution the FTE's by a total of 240, including a layoff of 118 people. That is a reduction in the work force of 3.8 percent. In conversations with our colleagues in the other six institutions, it is clear that they are developing plans right now for similar action in the very near future. There is no other way we can deal with this.

The single largest expense we face is personnel; 65 percent of our expenditures are for personnel, and in this arena, cutting wages on an individual basis is counterproductive, because recruitment in our labor market is extremely tight for all forms of personnel. And one of the reasons that our expenses have increased as sharply as they have is that we have been faced with a nursing shortage in which we felt it necessary to increase nurses' salaries significantly, for short- and long-term reasons. The short-term strategy was obviously to make it more attractive to nurses in the marketplace to come back to work or to increase their hours, so we did that and a starting nurse now is starting at $31,000 a year. The average nurse at the MGH is earning $44,000 a year.

Long term, we believe that will provide added attraction to enter the profession, because at the present time the number of entrants into nursing schools is down, and the long-term prognosis for having enough to meet our needs is very shaky. But the only way——

Mr. Levin. The consequence to the layoffs, some are going to say, well, that is the way a market should operate, you are becoming more efficient.

Dr. Buchanan. Yes, but normally in a marketplace those layoffs occur when the market is slack and there is no demand for service and there has been no growth in business. We have had growth in business, growth in demand, growth in intensity of service required. Our case mix index for our Medicare patients on average for these seven hospitals is 1.57. In other words, it is 57 percent greater than the average case-mix index in this country.

So, we are in a paradoxical situation where we are treating more people, who are sicker, who absolutely need to be in the institution. We have cut the length of stay from over 11 days down to 9 days in an institution which does not have any obstetrics, which typically has been the largest source of the shortening of an average length of stay. So, demand is up, intensity is up, resource utilization is up, payments are down for the elderly, and we happen to live in a State where cost shifting to the other payers is not possible to the extent necessary to cover our deficit on Medicare.

Thank you.

[The statements of Dr. Buchanan follow:]

STATEMENT OF J. ROBERT BUCHANAN, M.D., COALITION OF BOSTON TEACHING HOSPITALS

Thank you for the opportunity to appear before the Subcommittee to address proposed reductions in Medicare funding for the Indirect Medical Education adjustment. I am J. Robert Buchanan, M.D., General Director of Massachusetts General Hospital, and my testimony is given on behalf of the Coalition of Boston Teaching Hospitals, a group comprised of the Massachusetts General Hospital, Beth Israel Hospital, New England Deaconess Hospital, Brigham & Women's Hospital, New England Medical Center, The University Hospital, and Carney Hospital. All of these hospitals are members of the Association of American Medical Colleges. I am joined by Richard M. Knapp, Senior Vice President of that organization.

My purpose here today is to provide you with the facts about the current financial status of these institutions. I believe that this information will assist the Subcommittee as it confronts the difficult but necessary choices associated with meeting its budgetary targets.

To that end, my remarks center on these basic points:

(1) Teaching Hospitals, because of their unique role and contribution in health care training, delivery, and treatment, deserve careful consideration in deliberations on Medicare budget reductions;

(2) The group of seven teaching hospitals I represent are losing money, not making money, on Medicare patients and on operations overall;

(3) While Medicare costs in these seven hospitals are increasing at rates commensurate with the increased costs we have to pay for goods and services, Medicare revenues have increased negligibly over the last four years and are now significantly below our costs of providing services to the elderly;

(4) The proposed reductions in the Indirect Medical Education adjustment, combined with the other proposed reductions in Medicare reimbursement, would impose an unfair financial burden on these institutions and threaten their ability to provide services vital to their patients and to our national health care delivery system.

I. The Teaching Hospitals' Unique Contribution to the Health Care System

We are a major source of health care for the indigent. In 1988, these seven hospitals provided $133 million of uncompensated care, which represents 34 percent of all such care given in the State of Massachusetts. All but one of the hospitals provide between 12 percent and 16 percent of their patient days to Supplemental Security Income and Medicaid patients. These patients, as you know, make up the Medicare-defined disproportionate share population.

We provide a wide range of services not available elsewhere to the community: burn units, trauma units, transplant units, and neonatal care units. All fund health centers in low-income neighborhoods spread throughout the city. All are heavily utilized tertiary care centers accepting a significant number of admissions from community hospitals.

In 1988, our aggregate occupancy based on licensed beds was 81.7 percent. Based on staffed beds it was 88.2 percent. In 1987, the last year data is available, all Massachusetts hospitals had an average occupancy of 67.0 percent.

We are a crucial source of health professional training and research: in 1988 we had 1,528 residents in over 100 approved training programs. Upon completion of their training those residents filled both clinical and academic positions across the country. In 1983, the last year we compiled such data, we provided training to over 3,500 nurses and allied health professionals in approximately 400 separate programs.

As a group we received $244,941,000 of sponsored research awards from both the government and industry. Nowhere else in the country can you find the concentration of medical research resources that you do in Boston. Two of our institutions are the largest recipients of NIH funding to hospitals in the country.

Clearly Medicare reductions impede our ability to continue our present varied roles and will have a negative ripple effect on patient care throughout the health care system nationwide.

II. Financial Performance of Boston Teaching Hospitals

It is impossible for us to fairly and effectively debate the impact of proposed Medicare reductions on teaching hospitals unless we provide you an accurate picture of our financial situation. To that end, I am "opening our books" to you; all the data I will present comes from audited financial statements, our Board-approved budgets, and Medicare cost reports. It has been independently developed by Coopers and Lybrand.

The data shows that these seven Boston teaching hospitals lost money in 1987 ($20 million aggregate), lost money in 1988 ($14 million), and have budgeted an aggregate loss of $22 million in 1989. All seven hospitals budgeted operating losses for 1989, and the most recent figures, through February, show all seven hospitals experiencing losses from operations. Aggregate reported losses through February are $33 million. (Exhibit C)

It is important to note two additional factors here. These losses are occurring despite the high occupancies previously noted and despite admissions which have grown 9.1 percent over the last four years.

III. Inadequacy of Current Medicare Reimbursement

Analysis of the Medicare data shows a very disturbing trend: the cost of providing Medicare services has outpaced Medicare revenues./1

The results of our Medicare survey graphically demonstrate the inadequacy of Medicare reimbursement:

1. The hospitals' total Medicare margins have reversed dramatically in a very short period of time, from a $59.6 million gain in 1986 to a $37.0 million loss in 1989. That is a change from a gain of 14.5 percent to a loss of 8.5 percent. (Exhibit D)

2. Total Medicare costs over the same period have increased at a compounded annual rate of approximately 10.4 percent. Medicare payments are up only 5.8 percent for the entire four years. (Exhibit D)

3. Medicare inpatient discharges have increased over this four-year period, while Medicare inpatient revenue has decreased. Medicare discharges have increased 5.4 percent; total Medicare inpatient revenue has increased only 2.3 percent. (Exhibit E)

4. Medicare payments per case mix adjusted discharge have decreased, from $5,910 per discharge to $5,566 per discharge. During the same period the Medicare expense per case mix adjusted discharge has increased, from $4,836 in 1986 to $5,891 in 1989. Note that the compounded annual cost increase per discharge is 6.8 percent over this period, and that the rate of increase has slowed dramatically since 1987. (Exhibit F)

5. The Medicare inpatient payments and costs we have presented include all inpatient Medicare payments and costs. We understand that a definition of PPS margins that excludes capital costs and direct graduate medical education is in common use by HCFA and is how AAMC presents their data. Using this definition the seven hospitals' PPS margins become negative in 1989 and in aggregate yield a $13.1 million loss. (Exhibit G)

IV. Impact of Proposed Indirect Medical Education Reductions

The Administration's proposal to reduce the Indirect Medical Education adjustment from the present level of 7.7 percent to 4.05 percent would result in a dramatic loss of Medicare funds to Coalition hospitals: $29.5 million. A reduction in capital payments to 75 percent of cost, as proposed in the Administration budget, would mean an additional loss of $3.3 million. Moreover, if the PPS update factor fails to follow the DRI 5.8 percent market basket indicator in the area of hospital goods and services, but is set at 3.0 percent, Coalition hospitals will experience an additional $8.6 million shortfall. (Exhibit H)

The total impact of these budget proposals, applied to our 1989 budgets, would be to add on an incremental loss of $41,385,000, and bring our total loss from Medicare to $78,410,000, assuming no other reductions. (Exhibit H)

V. Conclusion

We simply cannot absorb such losses. In Massachusetts, we are prevented by law from shifting all these losses to the private sector. All of us have struggled to deal with the financial crisis we presently face, by reducing our budgets in every possible manner, without affecting patient care. Our efforts rank from reductions in work force to termination of services. Massachusetts General Hospital recently went through the very painful process of laying off 118 employees and eliminating in total 240 full-time equivalent jobs.

We need your help. I therefore strongly urge that you reject proposed reductions in the Indirect Medical Education adjustment and retain the present level of 7.7 percent.

/1 With the goal of ensuring accuracy, we have based these figures on Medicare cost reporting data for 1986, 1987, and 1988. 1989 data represents forecasts of revenue based on known Medicare payments and budgeted volume and expenses. 1989 expenses are projected Medicare expense categories based on Board-approved budgets.

Exhibit A

Boston Teaching Hospitals

General Statistics

	1988
Total Licensed Beds	3,991
Full-Time Equivalent Employees	21,941
Discharges	147,039
Outpatient Visits	1,590,132
Occupancy based on:	
Licensed beds	81.7%
Staffed beds	88.2%
Residents (Medicare definition)	1528
Research Funding	$ 244,941,000

Exhibit B

Boston Teaching Hospitals

Who We Serve

1988

Payor Utilization (%)	
Medicare	**35.5%**
Medicaid	**9.1**
Indigent	**5.1**
Total	**49.7%**
Boston Teaching Hospitals (7 hospitals) Uncompensated Care	**$ 133,491,000**
Total Uncompensated Care in Massachusetts (101 hospitals)	**$ 392,069,000**
Percentage of Uncompensated Care Provided by the Boston Teaching Hospitals	**34.0%**

Exhibit C

Boston Teaching Hospitals

Financial Trend Analysis

($ in millions)

	1986	1987	1988	Budgeted 1989	5 Months Actual 1989
Discharges	139,872	143,417	147,093	152,615	—
Total Operating Revenue	$ 1,130	$ 1,172	$ 1,307	$ 1,441	$ 553
Total Operating Expense	1,109	1,192	1,321	1,463	586
Net Operating Gain (Loss)	21	(20)	(14)	(22)	(33)
Operating Margin	1.87%	(1.74)%	(1.10)%	(1.54)%	(5.95)%

Exhibit C-1

Boston Teaching Hospitals

Operating Margin Ratios vs. National Operating Margin Ratios

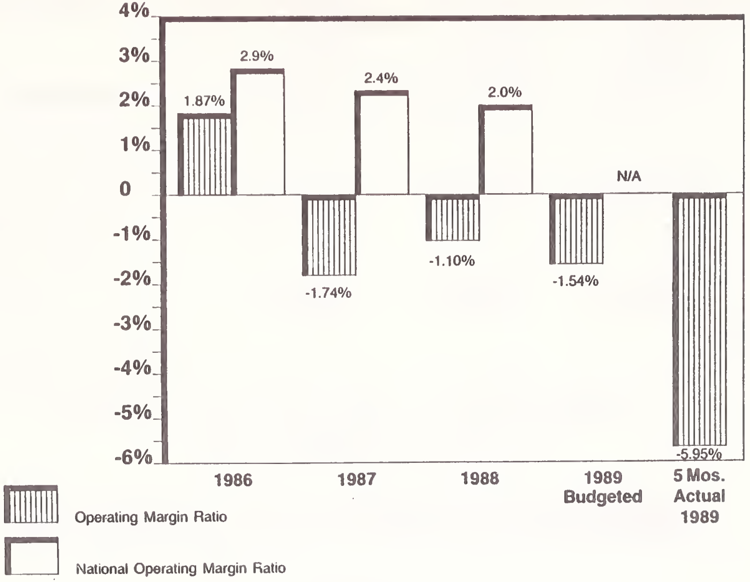


Exhibit D

Boston Teaching Hospitals

Medicare Trends
Total Payments ($ in thousands)

	1986	1987	1988	Budgeted 1989
Total Medicare Reimbursement	$ 411,650	$ 421,554	$ 424,328	$ 435,553
% Growth	—	2.4%	0.7%	2.6%
Total Medicare Expenses	$ 352,027	$ 392,821	$ 436,076	$ 472,578
% Growth	—	11.6%	11.0%	8.4%
Medicare Gain (Loss)	$ 59,623	$ 28,733	$ (11,748)	$ (37,025)
Medicare Margin %	14.5%	6.8%	(2.8)%	(8.5)%

Exhibit E

Boston Teaching Hospitals

Trends in Medicare Inpatient Payments

	1986	1987	1988	Budgeted 1989
Medicare Discharges	40,210	39,900	40,951	42,396
Total Medicare Inpatient:				
Payments (in thousands)	$367,107	$371,598	$368,177	$375,718
Costs (in thousands)	$300,370	$335,002	$369,918	$397,615
Payment Per CMAD	$ 5,910	$ 5,927	$ 5,608	$ 5,566
Cost Per CMAD	$ 4,836	$ 5,343	$ 5,635	$ 5,891
Medicare Inpatient Margin (in thousands)	$ 66,737	$ 36,596	$ (1,741)	$ (21,897)
% Margin	18.2%	9.9%	(0.5)%	(5.8)%

Exhibit F

Boston Teaching Hospitals

Expense Per CMAD vs. Revenue Per CMAD

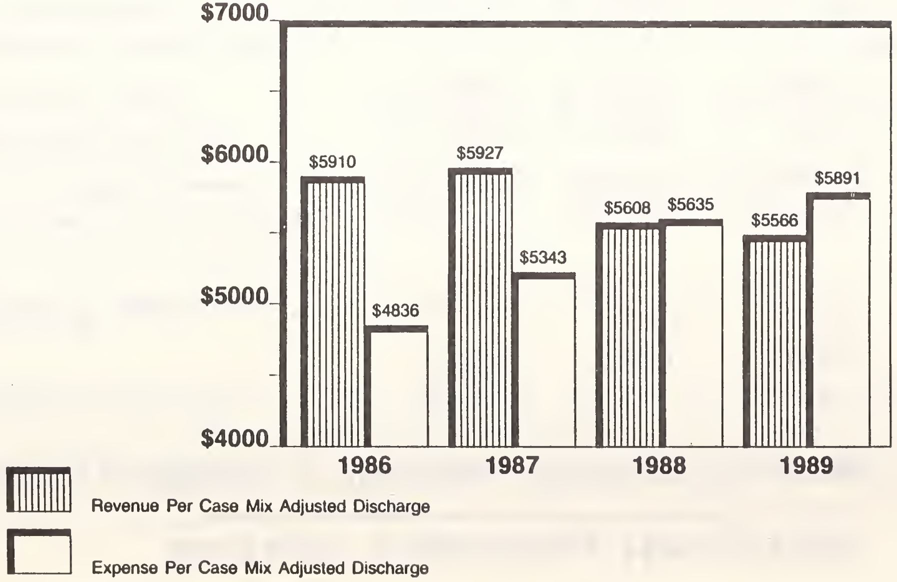


Exhibit G

Boston Teaching Hospitals

Medicare Trends PPS Margins
($ in thousands)

	1986	1987	1988	Budgeted 1989
PPS Payments	$ 306,629	$ 304,560	$ 298,587	$ 306,997
PPS Costs	$ 235,778	$ 261,157	$ 290,344	$ 320,143
PPS Margins	$ 70,851	$ 43,403	$ 8,243	$ (13,146)
PPS Margin %	23.1%	14.3%	2.8%	(4.3)%

Exhibit H

Boston Teaching Hospitals

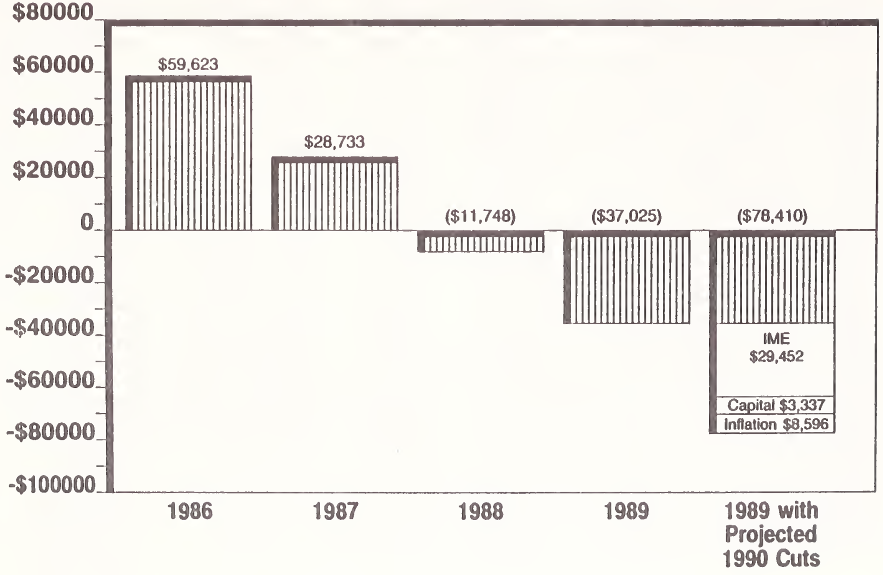
Impact of Proposed Medicare Reductions
($ in thousands)

1989 Medicare Operating Loss	$ 37,025
Indirect Medical Education Reduction to 4.05%	29,452
Capital Reduction to 75%	3,337
3% Inflation Update Shortfall	8,596
Total Operating Loss	$ 78,410

Exhibit I

Boston Teaching Hospitals

Medicare Operating Margin
(Dollars in Thousands)



STATEMENT OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES

The Association of American Medical Colleges (AAMC), which represents all of the nation's medical schools, 85 faculty societies, and over 350 major teaching hospitals that participate in the Medicare program, welcomes the opportunity to testify on the Administration's FY 1990 budget proposals to reduce the Medicare indirect medical education (IME) adjustment and Medicare payments for direct medical education costs. Teaching hospitals are an important component of the nation's health care system, providing all levels of patient care services, including tertiary care; serving as primary sites for the clinical education of health professionals, including physicians and nurses; and providing the environment for the conduct of clinical research and the introduction of new technologies. Because patient care, medical education, and research are produced simultaneously, it is not possible to identify fully and uniquely the cost of each specialized activity. However, these additional missions of teaching hospitals substantially increase their costs.

Congress has recognized the increased costs associated with teaching programs and has supplemented Medicare inpatient payments to teaching hospitals with the indirect medical education (IME) adjustment in the Prospective Payment System (PPS). In recent years, however, Congress, with Administration support, has reduced the level of the IME adjustment, maintaining that the adjustment factor is set too high.

The AAMC believes the IME adjustment is an important equity factor that recognizes the additional roles and costs of teaching hospitals. To help ensure that the IME adjustment and its impact on teaching hospitals are understood, this testimony reviews:

- the purpose and history of the indirect medical education adjustment;
- alternative estimates of the adjustment generated by government researchers;
- results of the AAMC's impact analysis of lowering the level of the adjustment; and
- the AAMC's policy recommendation on the IME adjustment.

The AAMC will also address the proposed changes in Medicare direct medical education payments in the final section of the testimony. First, however, a brief overview of the Prospective Payment System is necessary to understand how the IME adjustment is calculated and why it serves a broader purpose than its name implies.

OVERVIEW OF THE PROSPECTIVE PAYMENT SYSTEM

In December, 1982 the Secretary of the Department of Health and Human Services (HHS) proposed a hospital prospective payment system for Medicare. Enacted in 1983, the system was intended to allow the Federal government to hold down health care expenditures and provide hospitals a financial incentive to deliver services efficiently. Hospitals and the Federal government would also benefit from the predictability of the flow of Medicare payments.

In contrast to the cost reimbursement system used for nearly twenty years, the PPS pays hospitals a fixed amount, determined in advance, for the care of Medicare patients in each of 477 diagnosis-related groups (DRGs). The DRG classification system distinguishes many important patient characteristics that are highly correlated with hospital costs, such as principal diagnosis, presence or absence of secondary diagnoses, and whether or not certain major surgical procedures were performed during the hospital stay. However, DRGs do not distinguish severity of illness within diagnostic groups nor do they account for many other characteristics that are likely to affect a patient's stay and costs, such as whether patients were transferred from other facilities.

Under the PPS, the amount of payment is determined by multiplying the standard, national price (different for urban and rural hospitals) by a DRG weighting factor that rates a particular DRG's complexity of treatment against the average Medicare case. Hospitals are at financial risk if the cost of treatment exceeds the DRG price, but they may retain the difference between the DRG-based price and the cost of delivering services for patients in given diagnostic groups.

The PPS balances the concept of a standard national price, which is intended to promote efficiency, with the recognition that costs vary among hospitals, often due to factors beyond their control, such as location, types of patients, level of teaching activity, and share of low-income patients. As enacted and amended, PPS payments to hospitals are calculated using the standard national price per discharge and computing an individual hospital payment amount based on six factors:

1. the urban/rural location of the hospital determines the base rate paid for a discharge;
2. the area wage level for each geographic location adjusts the base rate for labor differences;
3. the hospital's case mix adjusts the payment for the types of patients that are treated in a facility as determined by their classification into DRGs;
4. outlier payments for cases that have an extremely long length of stay or extraordinarily high costs partially compensate hospitals for the atypical severity of some patients;
5. the disproportionate share adjustment partially compensates hospitals for the above average costs of caring for the aged poor; and
6. the IME adjustment compensates teaching hospitals for the cost impact of their special missions.

All hospitals' PPS payments are adjusted by the first three factors: location (urban/rural), area wage level, and case mix. Not all hospitals receive payments for outlier cases, or the disproportionate share, or indirect medical education adjustments.

Since the PPS departed substantially from the previous cost-based reimbursement system, its implementation was phased in over several years. In the early years of the PPS, hospitals were paid a blend of their hospital-specific costs and a national standard rate. The IME adjustment was applied only to the Federal portion. By Federal Fiscal Year 1988, hospitals were paid 100 percent on the national rate, and the IME adjustment was applied to the entire payment.

THE PURPOSE OF THE INDIRECT MEDICAL EDUCATION ADJUSTMENT

The "indirect medical education" adjustment is mislabeled and its purpose is misunderstood. While this payment compensates teaching hospitals for education and related program costs, its purpose is much broader. Both the Senate Finance and the House Ways and Means Committees specifically identified the rationale behind the adjustment:

> This adjustment is provided in light of doubts...about the ability of the DRG case classification system to account fully for factors such as severity of illness of patients requiring the specialized services and treatment programs provided by teaching institutions and the additional costs associated with the teaching of residents...the adjustment for indirect medical education costs is only a proxy to account for a number of factors which may legitimately increase costs in teaching hospitals (Senate Finance Committee Report, Number 98-23, March 11, 1983 and House Ways and Means Report, Number 98-25, March 4, 1983).

The IME adjustment is not to be confused with the Medicare payment for direct medical education costs, which is also part of the Medicare payment program. Payments for Medicare's share of the direct costs of graduate medical education programs are separate from the PPS and include payments for residents' stipends and fringe benefits, faculty salaries and benefits, and allocated overhead costs. The AAMC's comments on direct medical education payments are addressed in the final section of this testimony.

THE HISTORY OF THE INDIRECT MEDICAL EDUCATION ADJUSTMENT

The Origin of an Adjustment for the Increased Costs of Teaching Hospitals

In order to understand the origin and history of the IME adjustment, it is important to understand several events prior to implementation of the PPS, including the initial routine cost limits of the 1970s and how they were adjusted for teaching hospitals. Even though the Medicare program initially reimbursed all allowable costs of hospitals for the care of Medicare beneficiaries, the Federal government recognized that costs among types of hospitals varied, and soon imposed limits on the amount of variability that was acceptable to the program. Section 223 of the Social Security Amendments of 1972 (P.L. 92-603) authorized the Secretary of Health, Education and Welfare to set payment limits on routine inpatient hospital costs. If a hospital's per diem costs were above the costs of comparable hospitals, those costs were not reimbursable under Medicare. The cost limits and the method of setting them evolved between 1974, when the regulations were first published, and 1979, when the cost limits were set at the 80th percentile of the costs of comparable hospitals, and hospital size, location (urban/rural), and area wage rates were taken into consideration in determining comparability among hospitals.

In 1979, when the Carter Administration sought to achieve some of its hospital cost containment objectives by further reducing Medicare payment limits, the teaching hospital community expressed concern that it would be harmed disproportionately. In response to this concern, government researchers studied the relationship between hospital costs and teaching status.

The researchers found that a hospital's intern and resident-to-bed ratio (IRB) was related to an increase in hospital costs, even when direct medical education costs such as residents' salaries were removed from the analysis. Using a statistical technique called regression analysis, analysts were able to predict the change in average Medicare cost per discharge (the dependent variable) associated with a given change in other factors, such as the intern and resident-to-bed ratio or area wages (the independent variables). The results of these empirical analyses provided statistical estimates of changes in average costs associated with changes in each independent variable. Throughout this testimony, the terms "empirical estimate" and "statistical estimate" refer solely to the results of a regression analysis.

Researchers found that routine costs per day in teaching hospitals increased on average 4.7 percent with each increase of 0.1 in residents per bed. As a result of the government researchers' finding of this statistical relationship between teaching hospital costs and the IRB, the Medicare routine cost limits for teaching hospitals were increased to incorporate a differential based on the IRB in each hospital.

The adjustment for the costs of teaching hospitals was subsequently included in the extension of the routine cost limits to cover total operating costs per discharge as legislated by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). The magnitude of the adjustment was determined by a statistical analysis similar to the one used to set the adjustment to the routine limits.

The Adjustment for Teaching Hospital Costs Under the PPS

In the Secretary's December 1982 proposal for a new Medicare payment system, the resident-to-bed adjustment to the cost limits under TEFRA was converted to a PPS payment (the IME adjustment) to adjust for the higher costs of teaching hospitals:

> The indirect costs of graduate medical education are the higher patient care costs incurred by hospitals with medical education programs...there is no question that hospitals with teaching programs have higher patient care costs than hospitals without. The Department believes that recognition of these indirect costs should

> be accomplished through a lump-sum payment, separate and distinct from the base rate. This adjustment will be computed using methods that are similar to the methods currently used to adjust the old routine and new total cost limits... (Secretary of the Department of Health and Human Services, Hospital Prospective Payment for Medicare: A Report to Congress, December 1982, Pages 48-49).

Using the results of a regression analysis, the Secretary's estimate indicated that Medicare operating cost per case increased approximately 5.79 percent with each 0.1 increase in the number of residents per bed. However, two months after the Secretary's report was issued, the Congressional Budget Office (CBO) presented an impact analysis of the characteristics of hospitals that would gain or lose under the Secretary's proposed plan. CBO's estimate, as presented in Table A (following page), shows that the proposed DRG-based payment system would have adversely affected 71 percent of teaching hospitals if the IME adjustment had been set solely at its empirical estimate.

In response to the CBO analysis, the Administration suggested that the statistical estimate of 5.79 percent be doubled to 11.59 percent for each 0.1 increase in the IRB. The use of the regression estimates as a starting point resulted in an "empirically based" IME adjustment in the PPS. The doubling of the statistical estimate was accomplished by placing a multiplier at the beginning of the formula that calculates a hospital's IME adjustment factor. Congress supported this proposal of modifying the empirical estimate based on its expected impact on teaching hospital finances, and the empirically based IME adjustment was incorporated into the prospective payment legislation.

As more current and refined information became available, the IME adjustment was recalculated and lowered. The original adjustment of 11.59 percent was reduced to 8.7 percent in 1986 when better data became available. However, hospitals never received IME payments calculated at the 8.7 percent level because the disproportionate share adjustment was added to the PPS.

Since the implementation of the disproportionate share adjustment in 1986, policy makers and researchers have recognized that while some hospitals receive either the IME adjustment or the disproportionate share payment, other hospitals receive both. The 8.1 percent IME adjustment established by the Consolidated Omnibus Budget Reconciliation Act (COBRA) recognized the possibility of the overlap in these payments. The IME adjustment factor was reduced by 0.6 percent to finance part of the disproportionate share adjustment, resulting in an IME adjustment factor of 8.1 percent during the time the disproportionate share adjustment would be in effect.

The current 7.7 percent IME adjustment, enacted in OBRA 1987, took effect on October 1, 1988. Table B shows the history of the IME adjustment, including changes in the statistical estimate, which is generated by regression analysis of actual hospital data, and the multiplier. The inclusion of the multiplier in the formula operationalizes the concept of the "empirically based" IME adjustment factor.

Table B
HISTORY OF THE INDIRECT MEDICAL EDUCATION ADJUSTMENT

Time Period	Statistical Estimate (%)	Multiplier	Adjustment Factor (%)*
10/1/83 - 4/30/86	5.795	2.00	11.59
5/1/86 - 9/30/88	4.05	2.00	8.1
10/1/88 - Present	4.05	1.89	7.7

* Applied only to the Federal portion of a hospital's PPS payment. This portion was 25 percent in Federal FY 1984 and 50 percent through April 30, 1986. Not until FY 1988 was the IME adjustment factor applied to 100 percent of a hospital's PPS payment.

Table A
Estimated Average Penalties and Bonuses Under the Administration's Proposed DRG-Based Payment System By Type of Hospital[a]

	All Hospitals		Hospitals That Would Gain		Hospitals That Would Lose	
	Percent Distribution of Hospitals	Aggregate Effect as Percent of Reimbursements[b]	Percent Distribution of Hospitals	Aggregate Effect as Percent of Reimbursements[c]	Percent Distribution of Hospitals	Aggregate Effect as Percent of Reimbursements[d]
All Hospitals	100	0[e]	61	+23	39	−12
Bed Size						
Less than 100	49	+23	80	+35	20	−10
100–299	34	+2	50	+21	50	−11
300+	17	−6	30	+17	70	−13
SMSA						
SMSA	52	−4	43	+20	57	−13
Non-SMSA	48	+19	81	+29	19	−6
Region						
Northeast	15	−4	45	+19	55	−12
North Central	28	−4	60	+21	40	−13
South	37	+8	72	+26	28	−9
West	20	−2	57	+23	43	−13
Teaching Status						
Teaching	18	−7	29	+18	71	−13
Nonteaching	82	+7	69	+24	32	−10
Ownership						
Nonprofit	57	−2	55	+20	45	−12
Government	31	+9	78	+29	22	−12
Proprietary	12	−1	48	+22	52	−13

SOURCE: Preliminary CBO estimate based on Medicare Cost Reports for 1980.

a. Assumes an average payment level needed to keep outlays at the same level as under TEFRA in fiscal year 1984. Average gains and losses are incremental to those under TEFRA, which are assumed to be the average for each group. Effects of phase-in and adjustments for exceptionally costly cases are excluded, but an adjustment for teaching hospitals is included.
b. Average calculated for all hospitals.
c. Average calculated for hospitals that would gain.
d. Average calculated for hospitals that would lose.
e. Because aggregate reimbursements were assumed to be the same as under TEFRA, increases in payments to some hospitals would be exactly offset by decreased payments in others.

Source: Nancy M. Gordon, statement before the Subcommittee on Health Committee on Ways and Means, U.S. House of Representatives February 14, 1983

The COBRA legislation modified the IME adjustment in a second very important way. In addition to a lower statistical estimate for the IME adjustment, the linear adjustment formula was respecified as a curvilinear formula. As a result, as the resident-to-bed ratio increases, IME payments increase at a slower rate.

Under the PPS, teaching hospitals receive IME payments as determined by their individual resident-to-bed ratios and the empirically based adjustment factor. The percentage add-on to the DRG payment varies among individual hospitals depending on their resident-to-bed ratios. The average resident-to-bed ratio in the nation's teaching hospitals is about 0.13. Government researchers generally define major teaching hospitals as institutions with at least a 0.25 resident-to-bed ratio. Academic medical center hospitals have an average resident-to-bed ratio of 0.50. For example, using the current IME adjustment factor of 7.7 percent, a hospital with a 0.05 resident-to-bed ratio would receive an additional 3.8 percent IME payment under the PPS. A hospital with a 0.25 resident-to-bed ratio would receive a 17.9 percent increase in the DRG payment and a hospital with a 0.50 resident-to-bed ratio would receive a 33.7 percent add-on payment. Therefore, hospitals with relatively high resident-to-bed ratios have experienced a greater percentage reduction in their IME payments than hospitals with lower resident-to-bed ratios.

The Interest in Teaching Hospitals' Financial Performance

Throughout the history of the PPS, the financial performance of teaching hospitals has been an additional consideration, beyond the statistical estimate generated by regression analysis, in determining the level of the IME adjustment. The first evidence of the importance of other factors in addition to the "statistical estimate" was the CBO impact analysis that showed teaching hospitals would be adversely affected by the proposed payment system relative to nonteaching hospitals and resulted in the doubling of the statistical estimate.

As the Medicare PPS was gradually implemented, government bodies, private research economists, and the hospital industry began to monitor the impact of the new payment system on the nation's hospitals. Two closely watched measures of the impact of the PPS on hospitals were PPS margins and total margins (the margin associated with all hospital operations, including all patient care and other income from investments and philanthropy). The Inspector General (IG) of the Department of Health and Human Services, the Congressional Budget Office and the Prospective Payment Assessment Commission (ProPAC), issued analyses of hospital PPS margins showing that, through the third year of PPS (1986-87), hospitals had done well under PPS and that teaching hospitals had significantly higher PPS margins than nonteaching hospitals.

The AAMC cited, in a statement submitted on August 1, 1988 to the House Budget Committee's Task Force on Health, three factors that contributed to the unexpectedly high margins of teaching hospitals in the initial years of prospective payments:

- teaching hospitals maintained above average occupancy rates. In a fixed price payment system where revenue varies directly with volume, teaching hospital occupancy rates contributed to positive financial performance;
- HCFA's use of 1981 case mix indices to establish the hospital-specific payment component of the PPS resulted in an overstated hospital-specific price for use during the phase-in transition period; and
- the original IME adjustment was incorrectly interpreted as a linear relationship and was based on incomplete 1981 data.

When the inappropriateness of the linear form was determined and when more current data were available, the AAMC did not oppose a recalculation of the IME adjustment, i.e., a decrease in the empirically based adjustment from 11.59 to 8.1 percent and the imposition of a curvilinear form on the adjustment factor.

Congress subsequently reduced the IME adjustment to 7.7 percent when the limit on disproportionate share payments was removed. The AAMC did not oppose these changes in light of the empirical findings on hospital costs and the financial performance of teaching hospitals in the early years of the PPS.

FEDERAL AGENCIES' ANALYSES AND RECOMMENDATIONS FOR THE IME ADJUSTMENT

The Federal government continues to examine the IME adjustment and make recommendations on the appropriate level of the adjustment. In recent months, both ProPAC and the General Accounting Office (GAO) have published independent analyses of the IME adjustment. Both legislative branch agencies have calculated several estimates using different types of regression models, more current data, and different combinations of variables. Table C shows that, depending on the technical specifications employed, statistical estimates range from nearly 4 percent to more than 7 percent. The Bush Administration's Office of Management and Budget (OMB) has also proposed a level for the IME adjustment. OMB's budget proposal is based on use of the current statistical estimate and the removal of the multiplier from the formula. Table C shows federal agencies' recommendations for the level of the IME adjustment for FY 1990.

Table C
ALTERNATIVE AGENCY RECOMMENDATIONS FOR THE FY 1990 IME ADJUSTMENT

Government Entity	Statistical Estimates	Recommendation
OMB (Bush Budget Proposal)	4.05%	4.05%
GAO	3.73 - 7.19%	5.09%, 6.26%
ProPAC	4.2 - 4.6%	6.6%

In its February 1989 report to Congress on spending options for reducing the Federal deficit, CBO has simulated annual budget savings using two options for the IME adjustment, 6 percent and 4 percent; however, CBO has not presented a formal recommendation for a specific IME percentage.

The GAO and ProPAC have taken different approaches in making recommendations for the level of the IME adjustment. While ProPAC has considered the results of a financial impact analysis in addition to the results of regression analysis in making its recommendation on the IME adjustment, GAO has based its recommendation solely on statistical analysis, using different specifications of the regression model. Relying on a regression model similar to the formula used to calculate PPS payments, GAO calculated a statistical estimate of 6.26 percent. Moreover, GAO has narrowly interpreted the purpose of the IME adjustment as a "medical education" adjustment:

> The indirect cost of medical education represents the portion of the higher patient care costs thought to be due to such factors as increased diagnostic testing, increased number of procedures performed, higher staffing ratios, and increased record keeping (General Accounting Office, Indirect Medical Education Payments Are Too High, January 1989, Page 2).

GAO briefly acknowledges that some studies suggest that indirect medical education costs ..."reflect the additional costs, beyond those measured by DRGs, of treating more severely ill patients at teaching hospitals" (Ibid. Page 18).

ProPAC has conducted its own analysis of the IME adjustment, and in making its recommendation for FY 1990, the Commission has viewed the adjustment as empirically based. The Commission uses the empirical estimate as one of several factors in making a recommendation on the appropriate level of the IME adjustment. In addition to considering equity in the distribution of PPS payments as a decision criterion, ProPAC will also monitor and consider the financial impact of lowering the adjustment for teaching hospitals and the overall financial viability of these institutions:

> The Commission believes that both the empirical estimate and the impact analysis should play major roles in establishing the level of the medical education adjustment (ProPAC, Report and Recommendations to the Secretary, March 1, 1989, Page 40).

In the initial years of the PPS, major teaching hospitals' PPS margins were high relative to some other types of hospitals. However, ProPAC's estimates of fourth-year PPS margins show a dramatic decrease (ProPAC public handout at February 22, 1989 meeting of the Council on Graduate Medical Education). In addition, recent analyses of hospitals' overall financial status show that "major teaching hospitals have considerably lower total margins when compared to other teaching and nonteaching hospitals" (ProPAC, Report and Recommendations to the Secretary, March 1, 1989, Page 40). ProPAC's analysis of hospital financial data from the 1987 Annual Survey of the American Hospital Association showed that the total aggregate margin (which reflects all sources of revenue and expense for the hospital, including uncompensated care) for major teaching hospitals was 2.5 percent compared to a total margin of 4.2 percent for nonteaching hospitals and 5.3 percent for other teaching hospitals (Presentation at January 31, 1989 ProPAC meeting). The Commission states that "lowering payments to teaching hospitals should be weighed in light of the impact such action would have on the quality of and access to care for Medicare beneficiaries" (ProPAC, Report and Recommendations to the Secretary, March 1, 1989, Page 40).

RESULTS OF THE AAMC'S IMPACT ANALYSIS

Data on a Group of Major Teaching Hospitals

To determine trends in teaching hospitals' financial position and to assess the impact of the Administration's proposal to lower the IME adjustment from its existing 7.7 percent to 4.05 percent, the AAMC analyzed financial data from 65 academic medical center (AMC) hospitals that belong to the AAMC's Council of Teaching Hospitals (COTH). Academic medical center hospitals are under common ownership with a college of medicine or have the majority of medical school department chairmen as the hospital chiefs of service. The tables attached to this testimony use data from the AAMC's FY 1988 COTH Survey of Academic Medical Center Hospitals' Financial and General Operating Data which is mailed annually to 121 academic medical center hospitals. AMC hospitals that responded to the survey by March 31, 1989 provided data from their most recently completed fiscal year, which for most of these institutions ended in June or September 1988. Because this analysis focuses on 1988 financial and Medicare data, hospitals that provided only 1987 calendar year data have been excluded. The PPS data reported in these tables are from the hospitals' "as submitted" Medicare cost reports. Operating and total margin data are reported from audited financial statements.

Because AAMC policy prohibits the release of hospital-specific data without permission of the hospital chief executive, the identity of individual institutions has been masked in all tables. However, an alphabetical list of the responding hospitals is provided in the Appendix preceding Tables 1 through 4.

For this analysis the PPS margin is defined as PPS revenue (DRG payment, disproportionate share payment, IME payment and outlier payments) less Medicare inpatient operating costs, divided by PPS revenue. This definition excludes Medicare revenue and costs associated with capital, direct medical education, PPS exempt patient care units, and some other categories. Because payments for these cost components are made on a cost or less-than-cost reimbursement basis, the margin for these items cannot be positive. Therefore, overall margins for Medicare inpatient beneficiaries will be less than the PPS margins shown in this analysis.

Findings

On average, the 65 AMC hospitals in our analysis experienced a marked decline in their financial position in 1988, as measured by PPS margins and total margins. Table 1 shows that average PPS margins for this group of AMC hospitals dropped from 18.6 percent in 1986 to 5.3 percent in 1988. While only 2 of the 55 reporting hospitals had negative margins in 1986, 19 of the 65 hospitals reporting 1988 data had margins less than zero.

Table 2 uses 1988 data to demonstrate the impact of the various types of PPS payments on hospital margins and the effect of cutting the IME adjustment in half. During the reporting period shown in Table 2, teaching hospitals received an IME payment at the 8.1 percent level; therefore, a reduction of the payment by one-half pays hospitals at the 4.05 percent level, assuming no change in the FY 1988 intern and resident-to-bed ratio. Average PPS margins for these hospitals would have been (a negative) -5.2 percent rather than (a positive) 5.3 percent in 1988, if the IME adjustment had been 4.05 percent.

Table 3 demonstrates that for these hospitals the IME and disproportionate share payments constitute a significant portion of their total PPS payments. On average, about one-quarter of these hospitals' total PPS payments can be attributed to these adjustments. However, a high percentage of these payments relative to the total payment does not necessarily guarantee a large positive margin.

Table 4 shows operating and total hospital margins for three years. As with PPS margins, there is a definite downward trend in both margins. Total margins, which include revenues and costs from all patients and endowment and investment income, for these hospitals in 1988 were one-half their 1986 level, falling from 6.2 percent in 1986 to 3.1 percent in 1988.

The average operating margin was negative in 1988. However, average operating margins are affected by the accounting treatment of government appropriations. Some of these hospitals receive state or county/municipal appropriations to finance operations; the funds are sometimes treated as non-operating revenue on the financial statement. When a government appropriation is recognized in the hospital's operating statement as non-operating revenue, a hospital may show a large negative operating margin, but its total margin may be positive.

Discussion

As the AAMC's analysis shows, the level at which the IME adjustment is set will have a profound operational effect on major teaching hospitals. The determination of the hospital-specific DRG price was a major contributor to the profits of major teaching hospitals in the early years of the PPS. When DRG prices were based 75 percent on the hospital-specific price component, major teaching hospitals earned their largest margins. Since the IME adjustment was applied only to the 25 percent Federal portion of the rate, it made a relatively small contribution to teaching hospitals' PPS margins. Today, with DRG prices based 100 percent on the national rate and payments for capital and direct medical education costs being reduced, teaching hospital margins are generally low and the adjustments, including the IME adjustment, are increasingly important to teaching hospitals.

AAMC POLICY RECOMMENDATION

The AAMC maintains the IME adjustment is a critically important equity factor in the Medicare PPS, compensating teaching hospitals for the higher costs they incur in providing patient care. However, its "medical education" label causes the adjustment to be viewed incorrectly as an educational payment.

The IME adjustment was originally developed to create a "level playing field" for teaching and nonteaching hospitals. It serves as a proxy to adjust for inadequacies in the PPS, including:

- inadequate recognition of differences within a DRG of the complexity of disease, intensity of care required, and resources utilized by patients in teaching hospitals;
- non-recognition of the teaching hospital's costs of maintaining both a broader scope of services and the capacity to provide specialized regional services;
- failure of the wage adjustment to account for differences between central city and suburban wage rates within metropolitan areas;
- decreased productivity resulting from including trainees in hospital programs; and
- additional ancillary services ordered by trainees involved in the diagnosis and treatment of patients.

The AAMC strongly supports the importance of considering other factors, such as financial impact, in addition to an empirical estimate in determining the level of the IME adjustment. Teaching hospitals are under the same budgetary pressures as other hospitals to provide care efficiently; moreover, they must also fulfill their unique educational and service missions, including provision of health care for the poor. The current IME adjustment of 7.7 percent for each 0.1 increase in the number of residents-to-beds represents a substantial reduction of over 30 percent, or nearly 4 percentage points, from the original adjustment of 11.59 percent. Teaching hospitals have coped with the decreased rate, but they will not be able to withstand further reductions, particularly since margins for both Medicare and non-Medicare cases are dropping rapidly. Therefore,

> The Association of American Medical Colleges firmly opposes any proposed reduction in the IME adjustment below its current level of 7.7 percent for each 0.1 increase in a hospital's number of residents-to-beds.

DIRECT MEDICAL EDUCATION PAYMENTS

Hospitals that train health professionals have multiple functions. In addition to providing medical care to individual patients, these hospitals provide the resources for the clinical education of physicians, nurses, and allied health professionals. To provide this experientially-based clinical training, hospitals incur educational costs related to patient care. These added costs include resident stipends and benefits, salaries and benefits for faculty supervision of trainees, classroom space, supplies, clerical support, and allocated overhead. Medicare has always shared in the costs of these approved education activities on a reasonable cost basis.

Historically, payment for graduate medical education costs was open-ended. That is, there was no restriction on the number of years that Medicare reimbursement would financially support a resident's training. During the development of COBRA, Congress proposed to limit the number of years for which Medicare payment would apply. With the passage of COBRA in 1986, Congress chose to restrict full reimbursement to hospitals for the costs of those residents within the minimum number of years of formal training necessary to satisfy specialty requirements for initial board eligibility, plus one year, up to a maximum of five years. The five-year count would be suspended, however, for a period of up to two years for training in a geriatric residency or fellowship program. Reimbursement for residents beyond the five-year level would be reduced by 50 percent. The AAMC did not oppose this legislative change.

Nursing and allied health education continue to be paid on the basis of reasonable cost, but the passage of COBRA in 1986 changed the method of payment for physicians in graduate training (residents). COBRA requires the calculation of a hospital-specific per resident amount, based on 1984 costs and updated to adjust for inflation. Each hospital's per resident amount is determined by dividing its allowable costs by its number of residents. These per resident payments are to become effective retroactively to July 1, 1985. However, the draft regulations to implement the COBRA legislation were published only recently (September 21, 1988, 53 Federal Register 36589) and have not yet been made final. We have yet to experience the impact of these changes in the payment system. Nonetheless, the Administration has proposed to further reduce payment for direct medical education by eliminating payment for classroom costs, the costs of supervisory faculty salaries, and allocated overhead.

> The Association of American Medical Colleges opposes any further legislative changes in the payment system for direct graduate medical education costs.

The AAMC believes that third-party payers, including Medicare, must support their proportionate share of the costs of supervision and other related educational costs to help ensure high quality patient care, and to preserve the high quality of residency programs. Further, ample supervision is necessary to monitor appropriately residents' development in an environment of rapidly changing patterns of practice. Supervising physicians must judge the clinical capabilities of residents, provide residents with the opportunities to exercise progressively greater independence, and ensure that the care of patients is not compromised. This supervising responsibility requires substantial time and commitment, and must be compensated.

CONCLUSION

Teaching hospitals are a diverse group of highly complex institutions providing the environment and resources for medical education and research for the nation and providing both basic and tertiary patient care services. The current emphasis on re-examining national policies in light of limited public resources places teaching hospitals and their vital activities at risk if their special roles and nature are not appreciated. A reduction in the IME adjustment would constitute a severe economic hardship for teaching hospitals and hinder their future capability to support adverse patient selection within DRGs, and provide high technology care, high cost services for referred patients, and unique community services such as burn and trauma units. National policy on health care delivery and payment must recognize the unique characteristics and diversity of teaching hospitals so that their fundamental missions can be preserved. A poorly conceived or short-sighted policy to reduce the IME adjustment and the direct medical education payment will undermine the ability of these institutions to fulfill their multiple responsibilities.

APPENDIX

ACADEMIC MEDICAL CENTER HOSPITALS PROVIDING DATA
FY 1986 - FY 1988

CRAWFORD LONG HOSPITAL OF EMORY UNIVERSITY
DUKE UNIVERSITY HOSPITAL
EMORY UNIVERSITY HOSPITAL
FOSTER G. MCGAW HOSPITAL (LOYOLA UNIVERSITY)
GEORGE WASHINGTON UNIVERSITY HOSPITAL
GEORGETOWN UNIVERSITY HOSPITAL
HAHNEMANN UNIVERSITY HOSPITAL
HARBORVIEW MEDICAL CENTER (U. OF WASHINGTON, SEATTLE)
HARBOR-UCLA MEDICAL CENTER
HERSHEY MEDICAL CENTER (PENNSTATE)
HOSPITAL OF THE UNIVERSITY OF PENNSYLVANIA
INDIANA UNIVERSITY HOSPITALS
JACKSON MEMORIAL HOSPITAL
LA COUNTY-USC MEDICAL CENTER
LOMA LINDA UNIVERSITY MEDICAL CENTER
LOUISIANA STATE UNIVERSITY HOSPITAL
MASSACHUSETTS GENERAL HOSPITAL
MEDICAL CENTER HOSPITAL OF VERMONT
MEDICAL COLLEGE OF GEORGIA HOSPITAL AND CLINICS
MEDICAL COLLEGE OF OHIO HOSPITAL
MEDICAL COLLEGE OF PENNSYLVANIA
MEDICAL COLLEGE OF VIRGINIA HOSPITALS
NEW ENGLAND MEDICAL CENTER
NORTH CAROLINA BAPTIST HOSPITALS, INC.
THE NORTH CAROLINA MEMORIAL HOSPITAL
NORTHWESTERN MEMORIAL HOSPITAL
OHIO STATE UNIVERSITY HOSPITALS
OREGON HEALTH SCIENCES UNIVERSITY HOSPITAL
REGIONAL MEDICAL CENTER AT MEMPHIS
RUSH-PRESBYTERIAN-ST. LUKE'S MEDICAL CENTER
SAN FRANCISCO GENERAL HOSPITAL AND MEDICAL CENTER
SCOTT & WHITE MEMORIAL HOSPITAL
SHANDS HOSPITAL (UNIVERSITY OF FLORIDA)
ST LOUIS UNIVERSITY
STANFORD UNIVERSITY HOSPITAL
TEMPLE UNIVERSITY HOSPITAL
THOMAS JEFFERSON UNIVERSITY HOSPITAL
TULANE UNIVERSITY MEDICAL CENTER
UNIVERSITY HOSPITAL (COLORADO)
UNIVERSITY HOSPITALS OF CLEVELAND
UNIVERSITY MEDICAL CENTER (TUCSON, ARIZONA)
UNIVERSITY OF ALABAMA HOSPITALS
UNIVERSITY OF CALIFORNIA, DAVIS
UNIVERSITY OF CALIFORNIA, IRVINE
UNIVERSITY OF CALIFORNIA, LOS ANGELES
UNIVERSITY OF CALIFORNIA, SAN DIEGO
UNIVERSITY OF CALIFORNIA, SAN FRANCISCO
UNIVERSITY OF CHICAGO HOSPITALS
UNIVERSITY OF CINCINNATI HOSPITAL
UNIVERSITY OF KANSAS HOSPITAL
UNIVERSITY OF KENTUCKY MEDICAL CENTER
UNIVERSITY OF MARYLAND MEDICAL SYSTEM
UNIVERSITY OF MICHIGAN HOSPITALS
UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC
UNIVERSITY OF MISSISSIPPI
UNIVERSITY OF MISSOURI HOSPITAL AND CLINICS
UNIVERSITY OF NEBRASKA HOSPITAL
UNIVERSITY OF NEW MEXICO HOSPITAL
UNIVERSITY OF SOUTH ALABAMA MEDICAL CENTER
UNIVERSITY OF UTAH HOSPITAL
UNIVERSITY OF VIRGINIA HOSPITALS
UNIVERSITY OF WASHINGTON HOSPITALS
UNIVERSITY OF WISCONSIN HOSPITAL AND CLINICS
VANDERBILT UNIVERSITY HOSPITAL
YALE-NEW HAVEN HOSPITAL

NOTE: HOSPITALS ARE LISTED IN ALPHABETICAL ORDER. HOSPITAL ORDER HAS BEEN CHANGED IN THE ACCOMPANYING TABLES.

HOSPITALS IN WAIVERED STATES PROVIDE PPS DATA AS IF THEY WERE BEING PAID UNDER FEDERAL PAYMENT RULES.

TABLE 1: PPS MARGINS* IN SELECTED ACADEMIC MEDICAL CENTER HOSPITALS: FY 1986 - FY 1988

RANKED BY FY 1988 PPS MARGIN

	PPS MARGINS*		
HOSPITAL	FY 86	FY 87	FY 88
A	25.20%	20.27%	30.03%
B	19.26%	12.42%	28.66%
C	28.15%	26.91%	27.84%
D	36.04%	11.40%	25.88%
E	N.A.	N.A.	24.78%
F	32.71%	33.72%	21.77%
G	26.22%	21.31%	21.25%
H	2.11%	3.54%	20.19%
I	7.09%	12.37%	18.58%
J	N.A.	N.A.	16.99%
K	22.27%	15.39%	16.48%
L	34.98%	20.17%	16.46%
M	N.A.	N.A.	16.19%
N	20.74%	19.50%	15.22%
O	26.25%	11.45%	12.92%
P	23.68%	18.66%	12.53%
Q	10.91%	2.12%	11.68%
R	N.A.	N.A.	11.61%
S	18.39%	10.41%	10.97%
T	N.A.	N.A.	10.91%
U	N.A.	N.A.	10.78%
V	14.27%	16.07%	10.78%
W	20.72%	16.78%	10.66%
X	13.06%	10.15%	10.63%
Y	39.17%	31.25%	9.89%
Z	24.06%	15.93%	9.69%
AA	N.A.	N.A.	9.63%
BB	22.73%	16.37%	9.30%
CC	25.30%	3.50%	9.11%
DD	8.52%	-22.79%	6.75%
EE	N.A.	N.A.	6.41%
FF	10.68%	-0.48%	6.22%
GG	23.40%	21.39%	5.05%
HH	20.26%	7.51%	4.94%
II	19.35%	12.07%	3.88%
JJ	14.38%	13.82%	3.23%
KK	20.33%	12.86%	2.76%
LL	20.61%	19.21%	2.51%
MM	13.82%	18.05%	2.48%
NN	23.06%	15.55%	2.42%
OO	25.64%	14.02%	1.80%
PP	24.74%	14.81%	1.62%
QQ	8.60%	-1.33%	1.24%
RR	-2.94%	-11.74%	1.22%
SS	12.82%	20.04%	0.53%
TT	15.92%	8.03%	0.09%
UU	28.88%	14.26%	-0.01%
VV	16.74%	10.13%	-0.59%
WW	10.07%	7.17%	-1.39%
XX	19.71%	17.55%	-1.95%
YY	36.68%	30.62%	-2.28%
ZZ	24.68%	10.02%	-3.37%
AAA	20.93%	23.23%	-3.47%
BBB	N.A.	N.A.	-3.57%
CCC	15.48%	N.A.	-3.93%
DDD	18.80%	15.21%	-4.94%
EEE	15.02%	5.04%	-8.20%
FFF	2.49%	0.18%	-8.30%
GGG	N.A.	N.A.	-8.76%
HHH	-0.16%	1.73%	-9.10%
III	3.86%	-11.60%	-9.63%
JJJ	14.94%	9.50%	-14.08%
KKK	14.65%	0.68%	-14.57%
LLL	8.98%	10.56%	-19.67%
MMM	7.06%	-4.76%	-20.66%
MEDIAN	19.35%	12.64%	5.05%
AVERAGE (WEIGHTED)	18.61%	13.24%	5.30%

* PPS MARGIN = PPS REVENUE (WHERE PPS REVENUE = DRG PAYMENT, DISPROPORTIONATE SHARE, INDIRECT MEDICAL EDUCATION, AND OUTLIER PAYMENTS) LESS MEDICARE INPATIENT OPERATING COSTS, DIVIDED BY PPS REVENUE.

SOURCE: ASSOCIATION OF AMERICAN MEDICAL COLLEGES, FY 1987 AND FY 1988 COTH ACADEMIC MEDICAL CENTER HOSPITAL SURVEY.

TABLE 2: CONTRIBUTION OF PPS PAYMENTS TO SELECTED ACADEMIC MEDICAL CENTER HOSPITALS' PPS MARGINS: FY 1988

RANKED BY DRG PAYMENT, OUTLIERS, DSH AND IME @ 4.05 PERCENT

HOSPITAL	DRG PAYMENT ONLY*	DRG PAYMENT AND OUTLIERS	DRG PAYMENT, OUTLIERS, AND DSH	DRG PAYMENT, OUTLIERS, DSH AND IME @ 8.1%	DRG PAYMENT, OUTLIERS, DSH AND IME @ 4.05%
B	0.00%	3.87%	15.27%	28.66%	22.54%
C	-4.67%	-0.22%	9.84%	27.84%	19.84%
A	-6.67%	-3.10%	5.40%	30.03%	19.55%
E	6.88%	8.88%	8.88%	24.78%	17.59%
G	-7.40%	0.59%	5.62%	21.25%	14.14%
H	-5.70%	-0.48%	1.59%	20.19%	11.86%
D	-26.14%	-21.07%	-8.85%	25.88%	11.81%
F	-19.20%	-12.84%	-2.64%	21.77%	11.21%
I	-17.70%	-11.86%	0.31%	18.58%	10.37%
J	-27.51%	-21.81%	-4.16%	16.99%	7.61%
N	-20.46%	-16.05%	-3.30%	15.22%	6.87%
L	-35.41%	-23.11%	-9.32%	16.46%	5.29%
K	-19.32%	-16.59%	-9.51%	16.48%	5.24%
M	-29.13%	-20.75%	-10.63%	16.19%	4.63%
R	-18.48%	-10.84%	-4.10%	11.61%	4.39%
T	-24.70%	-16.30%	-8.87%	10.91%	2.01%
O	-32.31%	-23.78%	-12.08%	12.92%	1.99%
Z	-30.71%	-16.13%	-7.35%	9.69%	1.90%
V	-19.68%	-14.79%	-10.10%	10.78%	1.43%
X	-22.19%	-15.38%	-10.98%	10.63%	0.99%
P	-25.46%	-20.38%	-14.11%	12.53%	0.97%
Y	-15.77%	-11.59%	-11.59%	9.89%	0.30%
U	-33.50%	-26.11%	-13.33%	10.78%	0.16%
S	-31.44%	-22.12%	-14.44%	10.97%	-0.15%
W	-32.41%	-22.68%	-14.80%	10.66%	-0.48%
BB	-29.84%	-18.33%	-13.72%	9.30%	-0.92%
CC	-35.35%	-26.12%	-14.48%	9.11%	-1.33%
Q	-26.06%	-19.32%	-19.32%	11.68%	-1.51%
AA	-26.37%	-21.59%	-17.38%	9.63%	-2.12%
JJ	-40.21%	-30.30%	-10.13%	3.23%	-3.02%
HH	-31.95%	-23.43%	-17.00%	4.94%	-4.89%
DD	-45.00%	-30.40%	-21.35%	6.75%	-5.46%
EE	-57.52%	-40.23%	-21.31%	6.41%	-5.66%
MM	-31.96%	-17.30%	-17.30%	2.48%	-6.50%
GG	-31.89%	-27.01%	-21.52%	5.05%	-6.60%
QQ	-29.29%	-22.00%	-16.65%	1.24%	-6.96%
LL	-35.19%	-27.71%	-19.66%	2.51%	-7.44%
OO	-34.23%	-24.34%	-18.89%	1.80%	-7.56%
KK	-44.24%	-30.47%	-23.13%	2.76%	-8.66%
FF	-41.19%	-35.89%	-29.60%	6.22%	-8.82%
NN	-38.11%	-29.41%	-24.34%	2.42%	-9.35%
RR	-41.24%	-35.63%	-22.61%	1.22%	-9.41%
XX	-34.29%	-25.33%	-18.39%	-1.95%	-9.56%
BBB	-38.24%	-27.14%	-16.29%	-3.57%	-9.56%
SS	-32.27%	-25.33%	-22.07%	0.53%	-9.62%
CCC	-36.35%	-20.47%	-16.27%	-3.93%	-9.75%
PP	-41.33%	-32.30%	-25.70%	1.62%	-10.38%
UU	-32.95%	-24.28%	-24.28%	-0.01%	-10.83%
ZZ	-27.13%	-19.94%	-19.94%	-3.37%	-11.04%
II	-44.22%	-32.64%	-31.46%	3.88%	-11.05%
WW	-49.83%	-38.24%	-25.30%	-1.39%	-12.08%
TT	-55.00%	-40.72%	-27.68%	0.09%	-12.10%
VV	-49.70%	-38.03%	-27.41%	-0.59%	-12.43%
AAA	-34.13%	-27.91%	-27.91%	-3.47%	-14.40%
GGG	-28.59%	-23.44%	-23.44%	-8.76%	-15.64%
KKK	-34.11%	-26.78%	-19.87%	-14.57%	-17.16%
YY	-58.15%	-53.88%	-37.63%	-2.28%	-17.35%
FFF	-52.82%	-42.25%	-29.29%	-8.30%	-17.87%
DDD	-53.33%	-38.47%	-38.47%	-4.94%	-19.39%
HHH	-51.41%	-42.54%	-33.55%	-9.10%	-20.09%
III	-46.27%	-39.25%	-34.87%	-9.63%	-20.95%
JJJ	-42.18%	-34.23%	-34.23%	-14.08%	-23.34%
EEE	-62.86%	-51.13%	-47.02%	-8.20%	-24.66%
MMM	-61.95%	-50.60%	-44.30%	-20.66%	-31.42%
LLL	-55.25%	-55.25%	-55.25%	-19.67%	-35.16%
MEDIAN	-32.41%	-23.78%	-17.30%	5.05%	-5.66%
AVERAGE (WEIGHTED)	-33.06%	-24.61%	-18.29%	5.30%	-5.19%

* DRG PAYMENT ONLY = MARGIN IS CALCULATED AS DRG PAYMENT LESS MEDICARE INPATIENT OPERATING COSTS, DIVIDED BY DRG PAYMENT. FOLLOWING COLUMNS CALCULATE MARGINS RESULTING FROM ADDITIONAL TYPES OF PPS PAYMENTS.

SOURCE: ASSOCIATION OF AMERICAN MEDICAL COLLEGES, FY 1988 COTH ACADEMIC MEDICAL CENTER HOSPITAL SURVEY.

TABLE 3: DISPROPORTIONATE SHARE AND INDIRECT MEDICAL EDUCATION ADJUSTMENTS AS PERCENTAGES OF TOTAL PPS PAYMENTS: FY 1988

RANKED BY FY 1988 PPS MARGIN

HOSPITAL	DSH AS % OF TOTAL PPS PAYMT	IME AS % OF TOTAL PPS PAYMT	DSH & IME AS % OF TOTAL PPS PAYMT	FY 88 PPS MARGIN	FY 88 IRB RATIO
A	6.10%	26.04%	32.13%	30.03%	0.6506
B	9.99%	15.80%	25.79%	28.66%	0.5000
C	8.03%	19.96%	27.99%	27.84%	0.5775
D	6.87%	31.90%	38.78%	25.88%	0.7070
E	0.00%	17.45%	17.45%	24.78%	0.3187
F	6.89%	23.78%	30.67%	21.77%	0.7653
G	4.22%	16.56%	20.78%	21.25%	0.5468
H	1.68%	18.90%	20.57%	20.19%	0.4736
I	8.89%	18.33%	27.21%	18.58%	0.4449
J	11.55%	20.30%	31.85%	16.99%	0.7214
K	4.63%	23.73%	28.36%	16.48%	0.7018
L	8.56%	23.58%	32.14%	16.46%	0.5978
M	6.35%	24.24%	30.59%	16.19%	0.7600
N	9.02%	17.92%	26.94%	15.22%	0.5195
O	7.35%	22.31%	29.65%	12.92%	0.4555
P	4.00%	23.34%	27.34%	12.53%	0.8091
Q	0.00%	25.98%	25.98%	11.68%	0.7013
R	5.16%	15.09%	20.25%	11.61%	0.5000
S	4.89%	22.21%	27.10%	10.97%	0.4139
T	5.23%	18.17%	23.39%	10.91%	0.5476
U	7.98%	21.27%	29.26%	10.78%	0.5413
V	3.31%	18.97%	22.27%	10.78%	0.4853
W	5.00%	22.18%	27.18%	10.66%	0.6978
X	3.07%	19.47%	22.54%	10.63%	0.5066
Y	N.A.	19.25%	19.25%	9.89%	0.4805
Z	6.36%	15.87%	22.23%	9.69%	0.3878
AA	2.67%	23.01%	25.68%	9.63%	0.6493
BB	3.11%	20.24%	23.35%	9.30%	0.5821
CC	7.33%	20.61%	27.94%	9.11%	0.6925
DD	5.34%	23.16%	28.49%	6.75%	0.5490
EE	10.41%	22.85%	33.26%	6.41%	0.4592
FF	3.35%	27.64%	30.99%	6.22%	0.7975
GG	3.37%	21.87%	25.24%	5.05%	0.5735
HH	4.23%	18.76%	22.99%	4.94%	0.4220
II	0.65%	26.89%	27.53%	3.88%	0.5631
JJ	13.60%	12.13%	25.73%	3.23%	0.4451
KK	4.44%	21.03%	25.47%	2.76%	0.4308
LL	5.13%	18.53%	23.67%	2.51%	0.5400
MM	N.A.	16.86%	16.86%	2.48%	0.4278
NN	3.07%	21.53%	24.60%	2.42%	0.5612
OO	3.62%	17.40%	21.02%	1.80%	0.4502
PP	3.90%	21.73%	25.64%	1.62%	0.6501
QQ	3.72%	15.34%	19.05%	1.24%	0.4073
RR	7.73%	19.44%	27.17%	1.22%	0.5320
SS	2.11%	18.51%	20.63%	0.53%	0.4492
TT	7.25%	21.75%	29.00%	0.09%	0.7506
UU	0.00%	19.53%	19.53%	-0.01%	0.4568
VV	6.07%	21.05%	27.12%	-0.59%	0.5851
WW	7.57%	19.09%	26.66%	-1.39%	0.6172
XX	4.77%	13.88%	18.66%	-1.95%	0.3011
YY	7.85%	25.68%	33.53%	-2.28%	0.7710
ZZ	0.00%	13.81%	13.81%	-3.37%	0.3078
AAA	0.00%	19.11%	19.11%	-3.47%	0.4767
BBB	7.60%	10.94%	18.54%	-3.57%	0.3114
CCC	3.11%	10.62%	13.73%	-3.93%	0.3462
DDD	0.00%	24.22%	24.22%	-4.94%	0.4308
EEE	2.00%	26.40%	28.40%	-8.20%	0.6366
FFF	7.63%	16.24%	23.87%	-8.30%	0.4689
GGG	N.A.	11.90%	11.90%	-8.76%	0.3810
HHH	5.15%	18.31%	23.46%	-9.10%	0.5397
III	2.56%	18.71%	21.27%	-9.63%	0.6448
JJJ	N.A.	15.01%	15.01%	-14.08%	0.3251
KKK	5.21%	4.42%	9.63%	-14.57%	0.1014
LLL	0.00%	22.92%	22.92%	-19.67%	0.6432
MMM	3.50%	16.38%	19.88%	-20.66%	0.4685
MEDIAN	4.89%	19.47%	25.24%	5.05%	0.5320
AVERAGE (WEIGHTED)	4.06%	19.95%	24.01%	5.30%	N.A.

SOURCE: ASSOCIATION OF AMERICAN MEDICAL COLLEGES, FY 1988 COTH ACADEMIC MEDICAL CENTER HOSPITAL SURVEY.

TABLE 4: OPERATING AND TOTAL MARGINS FOR SELECTED ACADEMIC MEDICAL CENTER HOSPITALS: FY 1986 - FY 1988

	OPERATING MARGINS			TOTAL MARGINS		
HOSPITAL	FY 86	FY 87	FY 88	FY 86	FY 87	FY 88
A	7.47%	-4.05%	-4.16%	11.77%	0.46%	0.77%
B	11.58%	6.10%	-10.99%	13.41%	7.86%	9.87%
C	19.85%	18.96%	14.45%	19.85%	19.51%	14.83%
D	5.92%	-0.48%	0.01%	6.87%	0.52%	1.08%
E	N.A.	N.A.	10.51%	N.A.	N.A.	15.18%
F	1.57%	3.39%	1.51%	2.57%	4.48%	1.09%
G	2.90%	10.05%	5.49%	3.08%	8.42%	5.92%
H	3.34%	5.93%	4.03%	3.34%	5.93%	4.03%
I	9.29%	8.37%	9.37%	8.37%	9.29%	9.37%
J	N.A.	N.A.	1.18%	N.A.	N.A.	2.46%
K	6.90%	5.17%	3.99%	6.99%	5.34%	3.79%
L	-40.36%	-34.84%	-43.40%	-1.19%	-0.81%	-0.77%
M	N.A.	N.A.	-88.48%	N.A.	N.A.	-2.03%
N	-7.86%	-11.98%	-13.05%	-7.86%	-11.98%	-13.05%
O	0.82%	-1.57%	-5.00%	1.66%	0.04%	-3.47%
P	5.00%	5.34%	7.42%	5.01%	5.32%	7.89%
Q	15.20%	11.61%	6.39%	15.20%	11.61%	6.39%
R	N.A.	N.A.	0.27%	N.A.	N.A.	1.52%
S	1.39%	0.29%	-1.09%	-2.41%	3.70%	0.57%
T	N.A.	N.A.	0.64%	N.A.	N.A.	0.54%
U	N.A.	N.A.	0.41%	N.A.	N.A.	4.77%
V	6.36%	5.87%	2.03%	6.16%	5.64%	3.31%
W	8.02%	1.91%	-0.66%	8.43%	6.39%	3.52%
X	8.14%	6.42%	3.53%	11.17%	9.77%	6.46%
Y	10.92%	10.69%	10.00%	15.48%	13.99%	12.56%
Z	10.73%	4.58%	3.64%	10.73%	4.58%	7.03%
AA	N.A.	N.A.	3.14%	N.A.	N.A.	8.51%
BB	7.77%	5.62%	5.44%	8.94%	6.92%	6.49%
CC	0.64%	-0.79%	-5.79%	9.49%	0.55%	1.79%
DD	14.00%	8.41%	7.72%	16.55%	11.38%	10.21%
EE	N.A.	N.A.	-5.03%	N.A.	N.A.	0.13%
FF	0.76%	3.51%	2.69%	0.91%	3.72%	3.17%
GG	2.47%	0.15%	-1.47%	6.63%	4.37%	2.30%
HH	-1.46%	-1.03%	-3.16%	0.91%	0.67%	-1.27%
II	2.26%	0.84%	0.89%	5.33%	3.95%	3.65%
JJ	-0.63%	0.13%	-0.29%	-0.64%	-0.13%	-0.47%
KK	2.59%	-0.85%	-4.76%	4.84%	1.85%	-2.13%
LL	7.45%	7.47%	6.73%	8.66%	8.88%	8.78%
MM	-2.31%	-1.71%	-3.35%	0.36%	0.01%	-0.46%
NN	7.66%	2.64%	0.65%	12.72%	4.62%	2.89%
OO	3.72%	1.55%	1.22%	5.31%	3.60%	3.47%
PP	8.67%	5.61%	5.43%	9.18%	10.09%	6.06%
QQ	7.77%	2.24%	2.71%	10.55%	2.55%	3.04%
RR	4.75%	1.43%	1.27%	7.89%	3.25%	3.12%
SS	0.03%	0.52%	5.59%	4.09%	4.02%	-3.03%
TT	3.61%	0.47%	1.81%	5.35%	1.87%	2.38%
UU	11.25%	4.64%	3.82%	18.45%	9.14%	3.73%
VV	-13.23%	-17.58%	-16.95%	1.47%	2.00%	1.16%
WW	5.06%	3.14%	3.36%	5.06%	3.14%	3.36%
XX	6.15%	3.75%	2.20%	6.15%	3.75%	2.20%
YY	-26.45%	-29.57%	-40.01%	-0.33%	-0.41%	-2.88%
ZZ	10.40%	6.26%	1.96%	10.63%	6.96%	2.59%
AAA	2.50%	5.50%	5.70%	5.44%	8.06%	8.15%
BBB	N.A.	N.A.	4.91%	N.A.	N.A.	5.55%
CCC	0.89%	3.53%	2.24%	1.82%	4.47%	3.05%
DDD	0.81%	0.24%	-1.10%	0.98%	0.75%	-0.42%
EEE	-4.72%	-6.05%	2.01%	-2.03%	-4.17%	3.45%
FFF	3.99%	3.92%	-4.06%	4.82%	5.49%	-2.31%
GGG	N.A.	N.A.	-24.17%	N.A.	N.A.	1.57%
HHH	3.18%	0.31%	3.82%	3.18%	0.31%	3.82%
III	-4.62%	-10.72%	-7.30%	2.60%	-0.04%	3.64%
JJJ	7.03%	8.32%	1.64%	8.33%	9.37%	2.44%
KKK	11.67%	10.47%	4.34%	13.54%	19.62%	6.12%
LLL	4.14%	-1.18%	-4.10%	4.14%	-1.18%	-4.10%
MMM	6.83%	4.70%	2.15%	7.53%	5.68%	4.24%
MEDIAN	4.14%	3.14%	1.64%	5.44%	4.37%	3.12%
AVERAGE (WEIGHTED)	2.58%	0.79%	-1.43%	6.16%	4.52%	3.05%

SOURCE: ASSOCIATION OF AMERICAN MEDICAL COLLEGES, FY 1987 AND FY 1988 COTH ACADEMIC MEDICAL CENTER HOSPITAL SURVEY.

Mr. Levin. All right. Do either of you want to add to that rosy scenario?

Dr. Buchanan. Well, I think this is a biopsy which typifies a group of institutions which we have heard discussed substantially this morning, namely major teaching hospitals. It is clear that any reduction in the payment for Medicare services to institutions in this coalition or like them elsewhere in the country would be extremely damaging to institutions which are essential to meeting the health care needs of their communities, and I think Mr. Knapp can put this in a broader perspective.

Mr. Knapp. Before I begin, I would like to say a word about my colleague, Jerry Anderson. He was kind enough about a month ago to share his proposal about which Congressman Pickle made some observations. We did not care too much for it then and we still do not.

On the other hand, it is ironic that the same Jerry Anderson is the person to whom we owe a large debt because he has done a lot of the work that allows you to see the performance of major teaching hospitals this morning. So, while we thank him for that activity, we are disappointed with the proposal he presented this morning.

Congresswoman Johnson this morning made some observations about the purpose of the indirect medical education adjustment. We took fairly seriously the language that was in the 1983 committee report of this committee with respect to that payment, which we have reproduced on page 5, and in addition, on page 20 of our own testimony we outlined the five basic purposes of the indirect medical education adjustment as we see it.

What I would like to do for the next few moments is to indicate that what you hear from Boston really is reflected in the data nationwide on average. We have 121 hospitals in our organization of 354 hospitals which we call medical center hospitals. They have two characteristics. One, they are under common ownership, like the University of Michigan, with the university, or they are institutions where the chairman of the medical school department and the chief of service in the hospital are the same individuals in the majority of cases. That would be a place like Harper/Grace and Wayne State University, where there is separate ownership. There are 121 of those hospitals. We have data on 65 of them for the years 1986, 1987, and 1988.

What I would like to do is just move quickly to the tables. Right in front of them is a list of the 65 hospitals, so you can see who they are.

It has been alleged that major teaching hospitals have done very well with respect to financial performance in the early years of PPS and, as you look at those tables, I think you can see that is true.

Medical center hospital margins have gone from 18 or 19 percent on patient Medicare PPS patients in 1986 down to 5 percent in 1988. They are clearly tumbling and they are tumbling rather rapidly.

A couple of points with respect to these margins: they exclude capital payments, they exclude direct medical education payments, they exclude the dollars for exempt units in the hospital, and they exclude outpatient payments. These are all cost or less than cost components of the system; therefore the margins are less than they might appear.

On the other hand, we do not want to get into an argument with the inspector general over the definition of profit margins so we present them to you in that form.

In addition, for fiscal year 1989, we assuredly fell further behind. We had market basket −2 or −2.5, depending on where you are located, and we had a further cut in the indirect medical education adjustment from 8.1 to 7.7.

How important are these adjustments? Table 2 outlines how this set of institutions perform without payments for outliers, disproportionate share and the indirect medical education adjustment. The left-hand column in the table is rather dramatic in that regard.

As you look across the table, you can see how important the IME dollars are. Outlier dollars help some, disproportionate share help some, but it is only the indirect medical education payment that brought us to a positive bottom line in 1988. You can see in the far column, if the administration's proposed cut were in place, we would have already had an average loss of over 5 percent for this set of institutions.

Table 3 shows even more directly how important these payments are. At the bottom of the table, you will note that disproportionate share payments are between 4 and 5 percent of inpatient PPS payments, and the indirect medical education payment is between 19 and 20 percent. So, as I think Dr. Vaneslow mentioned earlier, about 25 percent of our inpatient payments, notwithstanding those revenues that we have excluded, come from these two sources of funds.

How is this set of institutions doing overall, that is, for all payers, inpatient and outpatient? Table 4, on the last page, shows that these numbers are tumbling as well. We present both operating margins and total margins.

Total margins include gifts, grants and endowment income, and the reason I would suggest you pay more attention to total margin versus operating margins is that sometimes in public hospitals appropriations are not treated as operating revenue. That is why you see some large losses on the operating margin columns. Thus it is true that the operating margins as a result of that accounting are sometimes understated, so I would call your attention to the total margins. But once again, you can see that we have gone from a total margin—this is again for all payers, inpatient and outpatient—of 5.44 percent in 1986 for the median down to 3.12 percent in 1988. These are 1988 data and there is no sign of improvement for 1989. In fact, I am quite certain that we are falling further behind.

A number of actions have been taken by this subcommittee since PPS has come to pass. As was pointed out earlier, the indirect medical education adjustment was cut 30 percent. In addition, some major changes have been made with respect to the direct medical education passthrough. We have not opposed these changes. Our responses I believe have been measured and thoughtful, but I think we have reached the point where it is possible you will come back once too often. I do not think that this set of institutions can stand another round of cuts, therefore we oppose both changes that the administration has proposed.

I want to make a couple of comments with respect to observations that came before me. In the COBRA legislation in 1985, the direct medical education passthrough was changed substantially in policy. It used to be that we were paid on a passthrough basis. To be blunt about it, we spent it and you paid it. There was no limitation on it.

What happened in 1985 was that that amount of money that any hospital had for purposes of direct medical education was divided by the number of residents involved and a per-resident payment was to be calculated. I might say that since that legislation was passed in 1985, the administration finally put those regulations out in September, they are not final yet so we have not seen the impact of what they are going to produce.

But with respect to the subspecialty payment issue, in fact this subcommittee and the Congress have already taken an action, so that any resident who is in a specialty beyond first board eligibility, plus 1 year, with a maximum of 5 years, we only get paid at the rate of 50 percent, rather than full payment. Again, The AAMC did not oppose this. We thought it was not an unwise move to close the open-ended nature of that commitment and to make this policy decision with respect to specialty training.

One last item I'd like to mention is—and I am sure both Dr. Buchanan and I can both discuss some of the issues that were raised this morning—since 1960, the applicant per acceptance ratio with respect to medical school places has never been higher than 2.8. It is now at 1.7, and we believe it has hit bottom, because finally, for the forthcoming year, we have about 350 more applications than we had last year. We are hoping for a big comeback.

Thank you.

Mr. LEVIN. Well, the hour is late and let me just ask you a couple of questions. You know, these data are startling in a number of respects. Take your table 1—and I am sorry that everybody here does not have—some of you have the tables—the PPS margins, I guess these hospitals are listed according to their PPS margins, right?

Mr. KNAPP. Yes, sir.

Mr. LEVIN. And some of them are really high.

Mr. KNAPP. Yes, sir.

Mr. LEVIN. Now, those are not exactly comparable with the figures in table 4 in terms of total margins, so it is a little hard to make much sense, to see a clear pattern. Let me ask you this: Go back to PPS, why should we resist a change in terms of indirect medical adjustment for hospitals that have these very, very high PPS margins?

Mr. KNAPP. A couple of observations in that regard. Table 1 is Medicare only and Medicare inpatient only. Table 4 is total margins for all payers, inpatient and outpatient.

You might take note of the fact that hospital A, which shows a 30 percent positive margin on Medicare inpatient payments, shows that the hospital is barely breaking even overall in table 4.

Mr. LEVIN. I knew that you were going to say that. [Laughter.]

I looked at one and four to see how much comparability there would be, and it is a little hard, you know, just on this short notice, to take these charts and make a lot of sense, but let me put it another way.

There are some wide disparities here. There is not a straight line relationship between PPS margins to total margins. There seems to be some relationship, but it is hard to draw. Your position that we should not do anything essentially says that we will treat those with high margins the same as those with negative margins, and that does not seem to be a very rational system. Is it?

Mr. KNAPP. I think for hospitals generally you will find that there are some hospitals that are doing very well in Medicare PPS, and there are those who are not. I would suggest that there is no reason for the distribution of big winners and big losers to be any different in this group than there would be in a larger group of all hospitals across the country. I guess the question would be do you want to take a position that there is a point at which margins are too high for this set of institutions or for all institutions? That is a policy judgment that is on the table for you.

Mr. LEVIN. Surely, it would seem relevant——

Mr. KNAPP. Or too low, Dr. Buchanan reminds me.

Mr. LEVIN. Or too low. Surely, it would seem relevant. Take the Boston teaching hospitals that had a PPS margin of $70 million in 1986, where did all of that money go?

Dr. BUCHANAN. I honestly cannot tell you specifically where it went, because I do not have an intimate knowledge of all seven institutions. I can tell you that a lot of it went to upgrading plant and development of new technology programs. I think there is little doubt about that.

Mr. KNAPP. We have the same concern that you do. We arrayed these institutions in terms of the PPS margins, we tried to look at occupancy, we tried to look at case mix index, we tried to look at how much disproportionate share they get, we tried to look at how much of the indirect medical education money they get, we tried to look at their margins—put that all together—and we have shared a lot of that with you and we would certainly be willing to share whatever we have with your staff—and we cannot find the pattern that I guess all of us would hope to find.

I might also say that this set of institutions that you have before you is functioning at 80 percent occupancy of set up and staffed beds. We just cannot find that magic relationship that I think everybody is looking for.

Mr. LEVIN. Well, it makes your job all the tougher.

Mr. KNAPP. Yes, sir.

Mr. LEVIN. If the Budget Committee gives us a figure—I mean they will give us a figure—if they provide us a mark that is very difficult to reach, we are going to look for some rationale. I mean the trouble with these figures is that they would seem to give us none, which is maybe the way you would like it—you know what I mean—in the sense that the patterns are so erratic that we do not feel that we can pick out winners and losers in terms of any change in formula.

Why do you not do this, though it may not be directly in your interest, just keep looking at these figures and tell us if you see any relationships. It truly would be helpful, because we may have to do something.

Mrs. Johnson, we have known each other for so long, it is hard for me to call you Mrs. Johnson. We are just about winding up and we are looking at the testimony of Dr. Buchanan and Dr. Knapp.

Mr. CRATER. Dick Crater, chief financial officer at the General.

Mr. LEVIN. Why do you not spell that for the record.

Mr. CRATER. C-r-a-t-e-r.

Mr. LEVIN. We were just looking at the charts in the association testimony, to the tables. Unfortunately, they do not show any consistent patterns between PPS margins and either operating margins or total margins, so I am afraid we are going to be somewhat at sea without much of a rope to grab a hold of.

Dr. BUCHANAN. I am not sure Dr. Knapp can say it, but perhaps I will hazard it—I think that there would be some understanding on the part of our membership were the committee to reach a policy decision about how high the positive margins should be allowed to ride and how low the negative margins should be allowed to ride.

I think it is clear, in a situation where capital is not going to be reimbursed at dollar for dollar and a variety of other expenses are not going to be fully reimbursed, many of these institutions are going to need to develop a positive margin some place if they are going to continue to grow and develop programs which have made them the distinguished institutions they are and the community resources they are and the national resources that they are, so I would not want to be an advocate for a zero margin either way. But I think it is a rational position to take that the spread should not be so far apart from negative on the one side and hugely positive on the other.

Mr. LEVIN. All right. Mrs. Johnson, any questions?

Mrs. JOHNSON. I am sorry that I had to miss your testimony, that is the way it goes around here, but I will look back on it because it is a subject that I am very interested in.

When I look at the hospitals in my district that have done very well with indirect payments and indirect medical education payments and the compensatory payments, they are no longer doing well, first of all. They are beginning to cross over that zero line, but they did well because their patient mix was not loaded with uncompensated care and their Medicare percentage was relatively minimal, and until Medicare began to pass into the negative they were not desperate. Would you say generally that that is the situation, that it is the uncompensated care that is driving the hospitals' problems, rather than the slight plus or minus or adequacy of medical education subsidies?

Dr. BUCHANAN. In the data that I presented on behalf of the coalition of seven hospitals in Boston, I do not think I could honestly say that. I think that our losses are as much because the expense of caring for Medicare patients has grown so much more than the revenue for the care of those patients, and the lines have now crossed. Taking all the payments for Medicare into consideration, we have a real negative margin on the care of our Medicare patients. Add to that uncompensated care and a variety of other issues, and the problem is just that much worse. We have got a problem just dealing with Medicare in the Boston hospitals.

Mrs. Johnson. On the issue of medical education, could you just tell me what you think the indirect cost compensates for? What are the costs imposed on a teaching institution that other institutions do not have? I do not think that we are sufficiently clear about that and I do not want to have that piece of indirect education subsidy confused with case mix issues or other issues. Can a case be made simply for the indirect subsidy, the subsidy for the indirect costs of medical education?

Dr. Buchanan. My own view is that there are myriad ways in which we enrich the environment for the education of physicians, nurses, social workers, all kinds of health personnel and build into it supervisory and safeguard mechanisms that assure the quality of the services we provide our patients while we go through this educational process, taking people from novitiate status to essentially expert status.

The ways in which we do that are so numerous that I do not think we will ever achieve careful quantification of them. For me, the IME has always tried to address these matters as well as the the severity issue. But I think it is improper as you have stated earlier this morning, to view the IME as an issue directly related only to education. It has to do with a whole variety of things we have to do for that environment.

There was a lot of discussion this morning about why are we not training people in the outpatient department. The reality is that we are. Pediatrics and other boards have already incorporated requirements that we put people in the outpatient department, and to the extent that results in lesser productivity and inefficiencies and there are costs related to that, we are eating those costs at the moment. They are contributing in a whole variety of ways to the predicament we are in.

So, I would like to see us look at the situation as a delicate balance, a multivariate balance in which, if we pull the plug on any of them at the moment, we are going to topple this thing into a really critical state and I do not believe anybody wants that to happen. So the issue that Mr. Levin has raised, "is it proper to have positive margins that are 30 percent on the one hand and negative margins that go down to 20 percent," clearly I think we are back at a policy decision again, but I offered the view that the membership of the council of teaching hospitals at any rate probably would understand a rational spread there that addresses both budgetary and social goals.

Mrs. Johnson. That is interesting. Thank you, Mr. Chairman.

Mr. Levin. Thank you very much. Thank you to everyone and the staff.

We are now adjourned. Thank you.

[Whereupon, at 12:45 p.m., the subcommittee was adjourned, subject to the call of the Chair.]

[Submissions for the record follow:]

STATEMENT OF THE

AMERICAN ASSOCIATION OF DENTAL SCHOOLS

The American Association of Dental Schools (AADS) is pleased to have the opportunity to present a written statement to this subcommittee. AADS represents all of the dental schools in the United States, as well as advanced education, hospital, and allied dental education institutions. We are the only national organization concerned exclusively with the needs of dental education.

THE IMPORTANCE OF MEDICARE GRADUATE MEDICAL EDUCATION SUPPORT TO DENTISTRY

Reimbursement for Graduate Medical Education costs under the Medicare program has important consequences for dental residencies based in hospitals. The calculation of Graduate Medical Education cost reimbursement includes a consideration of the number of dental residents at a hospital. Faculty and residents in these programs provide dental consultation and services to Medicare beneficiaries, most of which is not reimbursed by Medicare. Thus, direct Graduate Medical Education payments help make oral health care available to Medicare patients by alleviating some of the financial burden faced by hospitals in providing these dental services.

There are a variety of dental residency programs that provide oral health care to Medicare beneficiaries. The two largest and most important hospital-based programs are General Dentistry and Oral/ Maxillofacial Surgery. In 1988, there were 757 Oral/Maxillofacial Surgery residents and 1287 General Dentistry residents nationwide; they represented approximately 90 percent of dental residents at U.S. hospitals.

Oral/Maxillofacial surgery is virtually the only dental service reimbursed by Medicare; coverage is limited to fractures of the jaw and certain types of surgery (such as those necessary to treat oral cancers).

General Dentistry residencies, like the internship year in medicine, provide training in the various dental specialties, as well as training in hospital protocol. General Dentistry residents treat a wide variety of patients, including the medically compromised, the handicapped, and those with AIDS. These residents work with their medical counterparts to make sure that costly life-saving procedures are not jeopardized by dental infection. For example, oncology patients receive diagnosis and treatment of oral disease from General Dentistry residents prior to radiation or chemotherapy treatment and before transplant surgery. Although such primary dental care is not reimbursed under Medicare, it is critical to a successful outcome for the Medicare patient. Those who complete General Dentistry residencies are able to undertake a wider range of clinical services and will need to refer fewer patients to specialists. This is especially important to the indigent, the handicapped, and people in rural areas. Often these patients face financial or logistical obstacles that make specialized care unobtainable.

Witnesses testifying before the Subcommittee on Health have noted the shortage of primary care practitioners in the medical area. Dentistry is experiencing similar problems. For example, the Department of Health and Human Services, in its Sixth Report to the President and Congress on the Status on Health Personnel in the United States (June 1988), noted that the number of dental specialists more than doubled between 1970 and 1986, from 9320 to 21,300. General practitioners increased only 31 percent during this same period. Cuts in the reimbursement of graduate medical education would threaten General Dentistry programs - which provide primary care training and thereby offer an alternative to the movement towards specialization in dentistry.

Emphasis on primary care training is important because there are approximately 793 dentally under-served areas in the United States as of December, 1988. The Sixth Report on Health Personnel concluded that the geographic distribution of dentists also continues to vary widely by region. Although over 1700 dentists are needed in these underserved areas, the Report notes: "Little change has been observed in either the number of sites designated or the estimated number of dentists needed to serve those designated sites."

Reimbursement for graduate medical education costs is an important source of support for primary care dental programs, since Medicare coverage is almost exclusively limited to oral surgery services, and most states do not cover dental services under Medicaid. The only other federal program (administered by the Health Resources and Services Administration) providing funds to General Dentistry programs supports start-up of fewer than 20 programs per year.

This lack of reimbursement for oral health services provided to Medicare beneficiaries runs counter to trends in dental disease. The recent National Institute for Dental Research (NIDR) survey of adult dental health points to the need for more care to be available to elderly patients. In 1960 almost 60 percent of older persons had no natural teeth; today that number has dropped to below 40 percent. The average age of persons who are diagnosed with oral cancer is 60, and root caries (cavities) affect up to 70 percent of older people who retain their teeth. In the United States, older persons are at greater risk of developing cavities than are 14 year old children.

Unfortunately, although there is an increasing need for dental care for the elderly, Medicare does not pay for 96 percent of dental care. Moreover, only 6 percent of elderly persons have dental insurance. The Graduate Medical Education reimbursement fosters access to dental services by providing some compensation to help offset the costs incurred by hospital dental departments in providing oral health care to Medicare patients.

FY 1990 Direct Graduate Medical Education Budget Recommendations

Direct Graduate Medical Education reimbursement pays residents' stipends and fringe benefits, faculty salaries and benefits, and allocated overhead costs.

Hospitals that train dental residents incur additional educational costs related to patient care, such as residents stipends, faculty supervision costs, classroom space, supplies, and clerical support.

However, the Administration proposes to further reduce payments for direct medical education by eliminating payment for classroom costs, the costs of supervisory faculty salaries, and allocated overhead. AADS opposes these proposed cuts. We urge third party payers, including Medicare, to support their proportionate share of the cost of supervision and other related educational costs to help ensure high quality patient care, and to preserve the high quality of residency programs. Further, ample supervision is necessary to appropriately monitor residents' development in an environment of rapidly changing patterns of practice. Such supervisor responsibility requires substantial time and commitment, which, in turn, requires compensation.

AADS urges the subcommittee to do everything possible to maintain the current level of Medicare graduate education payments.

CONCLUSION

By having Medicare help pay for these teaching costs, patients receive better care. Although the reimbursement does not offset the costs of providing dental services to Medicare beneficiaries, it does make it possible for the hospital to continue to support a dental department, which directly benefits patients by making available dental services (a significant number of which are provided without reimbursement). Reductions in the reimbursement for educational costs would result in a decline in comprehensive patient care, blunting advancements that have been made in recent years to integrate oral health care into comprehensive treatment of a patient's overall condition.

AADS thanks the subcommittee for considering these comments.

April 20, 1989

The Honorable Fortney H. Stark
Chairman
Subcommittee on Health
Committee on Ways and Means
United States House of Representatives
Washington, DC 20515

Re: Fiscal Year 1990 Budget
Issues Concerning Graduate
Medical Education

Dear Chairman Stark:

The American Medical Association is writing to express its views concerning the proposed cuts in direct and indirect medical education funding set forth in the Administration's fiscal year (FY) 1990 budget proposal. We request that this letter be included in the record of the April 11, 1989 hearing concerning graduate medical education funding that was held by the Health Subcommittee.

The AMA believes strongly that Congress should reject the proposed cuts in direct and indirect medical education funding set forth in the Administration's FY90 budget proposal.

The indirect medical education adjustment is intended to compensate teaching hospitals for costs indirectly related to the teaching of residents. These costs include the fact that teaching hospitals treat more complex and severe cases, provide more technologically intensive care, and provide more uncompensated or insufficiently compensated care to low-income and indigent patients.

We oppose strongly the Administration's proposal to cut the Medicare indirect medical education (IME) adjustment from 7.7% to 4.05%. In recent years, the IME adjustment has been decreased from 12.59% to 7.7%. A further major reduction could have a serious adverse impact on teaching hospitals' ability to provide quality patient care. Particularly hard hit would be inner-city and major teaching hospitals that provide substantial amounts of uncompensated or inadequately compensated care. In our view, an IME adjustment of no less than 6.6% on a curvilinear basis recognizes the need for program savings and also more accurately reflects hospitals' increased costs for treating the generally more severe needs of patients in these hospitals and for training residents. The IME adjustment should not be reduced below this level unless and until such a reduction can be justified by reliable statistical data and adequate assurances exist that such a reduction would not negatively affect the quality of patient care.

The AMA also is very concerned over the proposal to limit reimbursement of hospitals' direct medical education costs to residents' salaries and fringe benefits and allocated overhead. Under this proposal, program costs such as classroom space and supervision by teaching physicians would no longer be reimbursed. In our view, Medicare should continue to reimburse its fair share of all appropriate direct medical education costs, including costs incurred for classroom space and supervision by teaching physicians, since it is impossible to separate the service from the educational aspect of residency training.

We urge you to consider carefully our views.

Sincerely,

James H. Sammons MD

James H. Sammons, MD

JHS/tmw

amsa

The American
Medical Student
Association/Foundation

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Statement on	Graduate Medical Education and Its Support Under the Medicare Program
To the	Subcommittee on Health Committee on Ways and Means U.S. House of Representatives
By	Virginia Gurley, MSIV Legislative Affairs Director American Medical Student Association

April 11, 1989

The American Medical Student Association (AMSA) is a national organization of over 28, 000 medical students throughout the United States. We are an independent organization of physicians-in-training committed to the improvement of medical education, the prevention of disease, and equal access to affordable health care.

AMSA is glad for the opportunity to comment on the Subcommittee's review of graduate medical education (GME) and GME's support under the Medicare program. We hope to provide you with the perspective of physicians-in-training on this crucial and complex issue. Our comments are intended to address both the proposed FY90 budget cuts in direct and indirect GME funding, as well as broader aspects of Medicare support for GME.

GME funding for resident and intern stipends is crucial to physicians-in-training because without it many students could not afford to pursue a career in medicine. Further, GME support plays an important role in maintaining the quality of training and care provided by the institutions through which we are gaining our medical education, and in addition, we feel that the clinical services provided by residents and interns is an important contribution to the healthcare needs of our most vulnerable and needy citizens.

The GME funding issue is complicated in that it holds ramifications for the aggregate number of physicians, the continuing need for primary care physicians, the increasing need for training opportunities in ambulatory care settings, and the evolving role of academic medical centers.

AMSA actively supports initiatives in pre- and post-doctoral medical education which assist in making physician training, specialty selection, and practice distribution more responsive to the service needs of communities and the nation. We think it is possible to positively influence these national concerns through GME funding, as long as the need for equitable access to medical education and the multiple missions of academic medical centers are fully considered. These concerns are outlined below.

As regards access to medical education, there are some very important considerations. Representation within the medical profession of minorit~~y and~~ies

~~be~~ is less than their proportions in the general population. A factor contributing to the disproportionate composition of the medical profession is that the expense of obtaining a medical education is a significant obstacle for minority and disadvantaged students. We strongly belief that if GME ceases to include funding for intern and resident stipends, careers in medicine will become even less accessible to under-represented groups. Given that the average indebtedness of medical school graduates was over $38,000 in 1988, the lose of resident and intern stipends would likely preclude careers in medicine for many non-affluent students too. **Therefore, AMSA strongly recommends that alterations in Medicare support for GME stipends should be free of any threat to equitable access to medical training.**

Proposals to alter Medicare support for GME should also give careful consideration to the impact of any alterations on the multiple missions of academic medical centers. These missions include provision of the highest quality training in medicine, nursing, and allied health services, provision of environments supportive of advances in medical sciences and research endeavors, and provision of a tremendous volume of clinical services to the poor and critically ill.

There is an important relationship between the quality of care a physician can provide and the quality of the training through which that physician learned the practice of medicine. In turn, quality of medical training is very much a function of the degree of supervision and evaluation provided by clinical teachers. Such supervision and evaluation, of course, is dependent on the availability of faculty for teaching. The balance of ample opportunities to exercise clinical judgement with the availability of faculty to provide guidance when needed is an important criterion that medical students use when judging the quality of a residency training program.

Both research commitments and practice plan income obligations compete with teaching duties. As clinical faculty come under greater time pressures to generate income through their practice plan obligations, they will have less time for teaching and research. It is our concern that if faculty salaries are no longer supported by Medicare, the availability of faculty for supervision and evaluation of medical students and residents will decline even further, and quality of both training and patient care could be severely compromised. **Therefore, AMSA strongly recommends against alterations in Medicare support for faculty salaries that will result in further restrictions on supervision of medical students and residents, and hence, quality of medical training and patient care.**

Academic medical centers, although they constitute only six percent of all hospitals, provide nearly 50 percent of all the charity medical care delivered in this country. In addition, these hospitals serve a higher proportion of Medicare and Medicaid recipients than non-teaching hospitals. Within the teaching hospitals, a significant proportion of the care is provided by interns and residents. Indeed, it is estimated that 75 percent of an intern or resident's time is spent in delivering care to patients, and only 25 percent of their time is spent on educational activities. Although it maybe a misnomer to label the indirect medical education (IME) supplement as such, residents and IME funds are integral to the ability of teaching hospitals to provide such an overwhelming proportion of the free medical care.

To jeopardize IME funding for teaching hospitals would further jeopardize the already tenuous access to care that currently exists for the poor. In addition, it would result in discontinuation of intensive medical services, such as trauma care and burn centers, which are usually housed by teaching hospitals. **Therefore, AMSA**

strongly recommends that any proposals to decrease the IME Medicare adjustment assure alternative sources of funding so that specialized and free care can continue to be provided at no less than their current levels.

Given the debate on how many and what kind of physicians the nation needs, it is reasonable to consider whether GME funding might provide a means to control the physician supply pipeline. In our minds, a key question in the physician supply debate is how would our need for physicians change if all of our citizens were guaranteed access to health care? Rapidly changing practice patterns, increasing uncertainty as to who will decide standards of care, and increasing malpractice liabilities likely are some of the factors contributing to the declining medical applicant pool. It may be premature to actively deter people from careers in medicine, and as a result possibly undo all that has been accomplished through the Health Professions Training Act since 1963. If one is to consider turning down the flow on the physician pipeline, the control point should lie before the investment in four years of medical school training has been made by the student and society.

Regardless of whether or not there is an aggregate oversupply of physicians, there definitely is a shortage of primary care physicians, especially in rural and urban areas of the country. There is a good change that decreasing GME direct funding would exacerbate this problem. A study on the specialty selection, practice location, and patient populations of minority physicians demonstrated that minority physicians choose primary care specialties, locate in health manpower shortage areas, and serve Medicaid recipients and patients from their same racial or ethnic group at significantly greater rates than white physicians (Keith, et. al.:NEJM,313(24):1515,1985). As was already noted, minority and disadvantaged students usually have fewer family resources to draw on and incur larger educational debts. So certainly support for primary care stipends is important.

Another factor which may be just as important to encouraging primary care specialty selection as adequate stipend support, is adequate training for primary care practice. Medical student perceptions as to whether or not they will be adequately trained to practice their specialty has a very strong influence on their ultimate specialty choice. Primary care is largely practiced on an outpatient basis in ambulatory settings, whereas, most graduate medical education is provided in hospital settings, even primary care training. As all of medical care moves increasingly toward ambulatory settings, it is important that medical training for providing care in the ambulatory setting also be increased. Ironically, although it is less expensive to take care of patients in ambulatory settings, it is harder and more expensive to train residents in these settings. If alterations to IME funding are to be made, reimbursement for training in ambulatory settings would be a warranted and constructive change. Unfortunately, such a change is not likely to contribute to the Medicare budget trimming needs. In the meantime we are concerned that a decrease in IME funding could cause further delay in adjusting the training needs of medical students and residents to the needs of the nation. As was stated above, AMSA actively supports medical education which is responsive to the needs of communities and the country; the need for community responsive primary care is clear.

AMERICAN OSTEOPATHIC HOSPITAL ASSOCIATION
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STATEMENT OF THE
AMERICAN OSTEOPATHIC HOSPITAL ASSOCIATION
PRESENTED TO THE
HOUSE COMMITTEE ON WAYS & MEANS
SUBCOMMITTEE ON HEALTH
April 21, 1989

Introduction

It is a pleasure to present to the House Ways & Means Health Subcommittee the views of the American Osteopathic Hospital Association (AOHA), on the critical issue of financing graduate medical education. The Association is a national organization representing 178 osteopathic institutions, 117 of which are teaching hospitals.

With the recent hearing's emphasis placed on the number and types of physicians being trained, AOHA would like to provide a brief overview of the osteopathic hospital industry.

Osteopathic Hospital Profile

Osteopathic hospitals serve as the primary institutional care facilities for those individual consumers who choose to receive their care from the 28,000 practicing osteopathic physicians nationwide. Like all hospitals, osteopathic hospitals are facing fierce competition in today's healthcare marketplace. With nearly half of our institutions having less than 100 beds and 92% having less than 300 beds, the osteopathic hospital profile reflects a very special community orientation. Because of our inherently small size, our hospitals are especially vulnerable to changes in the marketplace. Since 1985, 30 osteopathic hospitals have closed and 2 no longer retain their osteopathic identity. Of these, 11 were teaching hospitals. These losses are felt in communities where we provide healthcare choice based on a distinctive medical philosophy that offers a wholistic, "hands-on" approach. Osteopathic medicine offers an extra dimension of traditional healthcare.

The Osteopathic Teaching Hospital

The training of osteopathic physicians is a major concern for osteopathic hospitals. The continued funding of graduate medical education is essential to the number of training positions we can provide. Presently, all of our teaching hospitals offer intern training and 70% provide residency training. Approved intern training programs within individual institutions and multi-hospital systems range from 2-86 positions. Approved residencies per hospital or system range from 1-101. The overwhelming majority of our teaching hospitals are community facilities and not academic health centers. In fact, all of our community hospitals with 200-299 beds are teaching institutions, while 70% with 100-199 beds have teaching programs. Only four of the fifteen osteopathic medical colleges currently operate teaching hospitals, giving further evidence that our programs are essentially community based.

Osteopathic Training Model

The primary mission of osteopathic teaching programs is the training of primary care community physicians. Half of all residents training in osteopathic residencies are in four primary care specialties: internal medicine, pediatrics, family medicine, and OB-GYN. All osteopathic physicians regardless of any future specialty, are trained as primary care physicians through the one year rotating internship. We do not offer the allopathic straight internship model.

Almost 50% of all AOA approved residency positions are in these four primary care specialties, and 55% of all Board certifications of osteopathic physicians are in these concentrations. Of all osteopathic physicians in practice, over 65% are engaged in the delivery of primary care.

The osteopathic teaching hospital role in training general practitioners and specialists begins during the osteopathic medical student's undergraduate training. Our educational model stresses clinical exposure through clinical clerkships. This type of hands-on clinical education is an essential ingredient to train the osteopathic physician. The osteopathic hospital has traditionally had primary responsibility for conduct of internships and residencies. Under the osteopathic graduate medical education model, all osteopathic physicians must enroll in a one-year rotating internship during which they receive clinical exposure in a multitude of medical areas. This rotating internship is required for program approval by the American Osteopathic Association (AOA) - the accrediting arm of the profession, and for licensure in most states. This builds the foundation for the osteopathic physician. After completing the rotating internship, the osteopathic physician can practice general medicine under all federal statutes and all state statutes with the exception of New Hampshire, where two years of post-graduate training is required for all physicians.

Residency training, especially in the primary care specialties, plays an important role in our teaching hospitals. The osteopathic's first year of residency is actually equivalent to PGY II in allopathic training programs. While our general practice model consists of a one-year rotating internship followed by one-year residency with an optional second year (three graduate years), other specialties require from two to six years additional training.

There are 1,833 approved osteopathic intern positions for 1988-89. We expect 1,615 graduating students to seek these positions in the coming year. While these figures appear positive, 324 intern positions are unfunded. This places osteopathic hospitals in a position of not being able to train all incoming graduates in an osteopathic setting. For the 500 approved residency training programs (18 specialty areas and 18 subspecialty areas), 2,036 approved training positions will be provided. Only 1,695 will be funded.

The Intern "Crunch"

The osteopathic profession is now facing a challenge regarding the long term ability of our teaching hospitals to provide the necessary programs needed for new physicians. Our hospital system is not growing and, in fact, is undergoing reconfiguration as the pressures of Medicare and other financing sources take hold. Osteopathic hospitals are faced with the challenge of reacting to these demands to constrain programs while meeting the increasing demands to train more physicians. This has resulted in an "intern crunch" in training all incoming graduates. In recent years, this had led to the development of intern programs in allopathic hospitals coordinated by osteopathic medical colleges.

We are currently trying to work out these problems within the profession, but the options are limited. Any federal or state policy initiatives that limit payment for teaching purposes will further exacerbate our problems.

Other Distinctions Between Osteopathic & Allopathic Training Programs

In addition to the rotating internship which is unique to the osteopathic training model, there are other distinctions between osteopathic and allopathic training programs.

Nearly all of the faculty are volunteer, (no pay, no practice plans) as are specialty college and certification board members and personnel. Instructors also carry a full patient load in addition to their training responsibilities.

Besides all conventional medical procedures, students studying osteopathic medicine are specially trained to perform osteopathic manipulative therapy (OMT). OMT is a procedure in which osteopathic physicians use their hands to diagnose and treat muscular skeletal problems when indicated. This additional procedure, with special facilities established in the hospitals for its use, enables comprehensive osteopathic care to be rendered to hospital patients.

Osteopathic training programs are initially approved by the AOA's Committee on Postdoctoral Training - a body equivalent to the Accreditation Council for Graduate Medical Education. The AOA Board has final approval authority. Pre-approval for residency programs is granted after periodic review by specialty college surveyors.

Another distinction is that osteopathic teaching hospitals are generally smaller than allopathic academic centers. As mentioned, every osteopathic hospital of 200-299 beds is a teaching hospital.

The Financing of Osteopathic Teaching Hospitals

The financing of osteopathic teaching hospitals comes primarily through third party reimbursement. There is essentially no grant support or other direct state or federal funding. For example, in 1987, only two federal grants were awarded to our teaching hospitals nationwide to support primary care specialty residencies (1 internal medicine, 1 pediatrics). In addition, only six general practice residencies received federal grant assistance. Therefore, private support through reimbursement by third party payers and patients themselves continue to be the only other funding sources available. Thus, additional federal cutbacks in funding would be devastating. Recent GME funding cuts have already resulted in the reduction of available internship and residency positions in some institutions. These cutbacks are felt more severely when coupled with the full implementation of the national prospective rate setting system and the anticipated budget cuts recommended by the Administration. This will all increase the pressure on an already taxed system due to insufficient available internship positions for the increasing number of osteopathic graduates.

Other Financing Considerations

The unique profile of the osteopathic training model presents additional financing considerations. If the current financing system is restructured, osteopathic teaching hospitals must be able to compete equally with allopathic GME programs for available funding despite the relative lack of resources, faculty trainers, and academic base of support. We must find mechanisms to make available necessary funding for osteopathic teaching hospital faculty development and for at least partial salary support for hospital teaching faculty and program directors. As our voluntary faculty faces increasing practice pressures and other demands, our hospitals will not be able to retain their traditional volunteer faculties.

The osteopathic profession is under increasing pressure to develop and create alternative training programs in non-osteopathic community institutions. These are being administered through osteopathic medical colleges or through affiliations with other hospitals. Some of these institutions may not have the ACGME approved programs or may not be optimal sites for osteopathic medical education training. In addition, some of these new programs may further tax the allopathic system which may also be facing similar financing and training pressures.

A continuing shrinking patient base coupled with increased competition for patients in community hospitals, is also resulting in less teaching opportunities. This may result in program and available position reductions especially with reduced reimbursement.

Salary Competition for Interns

Due to the increased debt of graduating medical students, internship and residency stipend competition is significant. In Michigan in 1986, for example, the average (PGY1) internship salary was $15,424 per year among the Detroit area's eight osteopathic hospitals. Among Detroit's major allopathic training hospitals, the average salary was $22,216. And, in Philadelphia, PA, staff salaries differ by as much as $9,000. Therefore, significant numbers of DOs chose to take non-AOA approved residencies due to the pay disparity per year of the $18,000 to $40,000 variation for the duration of the training program. This is also reflective of the national situation. When asked to hold the line on hospital costs, osteopathic hospitals have responded. Unfortunately, it results in not being competitive with allopathic teaching hospitals. This fact, coupled with the already intensified shortage of osteopathic training positions, this further erodes the bond between the osteopathic physician and the osteopathic hospital.

Due to these factors, one Michigan osteopathic hospital corporation's commitment to the promotion of primary care training, resulted in offering all interns and residents annual stipend increases of $2,400. While this was not novel, the second phase of the program was unique. They decided to offer an additional $2,400 per year to all residents in the four primary care residency tracks. The result has been a continuation of more of their own graduates in their osteopathic hospital based programs while also enhancing the image and prestige of the primary care specialties. We do not know if this will set a trend in the osteopathic world, but we see it as a recommitment to the training of community based primary care physicians - a basic tenant of our profession as well as a policy objective of the federal government. Perhaps, the federal government should consider a reimbursement mechanism that also rewards physicians that train in the specialty areas in the most need - primary care.

The American Osteopathic Hospital Association Federal Policy Perspective

Federal financing of postdoctoral training continues to be a priority concern. We strongly feel federal policy should be debated in terms of health policy not exclusively in the context of the federal budget deficit. We understand the constraints, but are beginning to worry when cutbacks will effect services and quality. While we support the current reimbursement formula, we do oppose recent federal initiatives to arbitrarily reduce direct and indirect graduate medical education payments. On direct expense side, full payment for training of interns and residents has already been modified through the establishment of a lid on the number of training years that are fully reimbursed. These significant changes have yet to be implemented through regulation, yet more cuts are being requested.

Payment for indirect medical education expenses have also been reduced significantly in recent years. Perhaps the last reduction was justified. However, a further halving of payments will directly affect our hospitals ability to continue training at near current levels, let alone expand to meet the demands of the osteopathic profession. Past cuts have not been evaluated nor has the potential impact of a fully national prospective payment system under Medicare.

Over the long term, AOHA would endorse a policy reform that embraces a fixed price approach combining direct and indirect payments. It should be biased toward primary care training, while recognizing the osteopathic model of training as separate yet equal.

Policy Issue Summation

As we have shown, osteopathic hospital based teaching programs by their very nature are smaller than others. They are community hospital based and currently stretched to the limit in their capacity to financially support the increased demand of osteopathic graduates. With an ever increasing influx of osteopathic medical school graduates, the traditional osteopathic teaching hospital finds itself faced with ever mounting pressures. The pressures are broadly based. Osteopathic graduates need intern and residency slots. Their concerns are real. Meanwhile, support for training is shrinking; the osteopathic hospital system is consolidating and tightening due to the comtemporary economics healthcare, with the result being that an increasing number of training opportunities are outside the osteopathic hospital. We strongly believe that if we are to have a pluralistic healthcare system with a real choice in medical practice and philosophy of care offered, then traditional osteopathic hospital and ambulatory based programs must continue to be supported as the site of first choice for graduate medical education training. This can't be accomplished without continued financial recognition. Even the slightest reduction can drastically reduce program size resulting in another osteopathic physician being forced to seek training from outside of his or her chosen profession.

The economics of healthcare precipitated by the Medicare prospective payment system, have led to a declining bed census and a dramatic growth in ambulatory services provided by osteopathic hospitals. Decreased caseloads in small teaching hospitals often mean refined training experiences and always mean less federal support.

In Pennsylvania, for example, osteopathic hospitals are finding that 32% of their medical education costs are not reimbursed. This is leading to consideration by some hospitals to reduce the size of their programs. In Michigan, osteopathic hospitals find themselves in a highly charged and competitive market. This has presented a different problem: the need to significantly raise stipends to keep osteopathic graduates from training in more lucrative allopathic programs. Meanwhile, the Department of Health and Human Services is seeking a further chipping away of the base of support.

Conclusion

In conclusion, federal financing of post doctoral training continues to be a priority concern for osteopathic teaching hospitals. As we continue to face a tremendous growth in medical graduates from the fifteen osteopathic medical schools and a shrinking osteopathic teaching hospital system, we cannot help but worry about the perpetuation of our traditional teaching programs.

Thank you for allowing us to present our views on this critical issue.

ASSOCIATION FOR HOSPITAL MEDICAL EDUCATION
MEDICARE PAYMENTS FOR COSTS ASSOCIATED WITH TEACHING PROGRAMS

The Association for Hospital Medical Education (AHME) represents community hospitals involved in the teaching of medical students, residents, interns and practicing physicians. Of the many hospitals with graduate medical education in our nation, approximately one thousand are non-profit community hospitals. Our member hospitals range in size from two hundred to over one thousand beds. Some of our larger institutions are tertiary care referral centers where the community they serve goes far beyond their immediate geographic area. On the other hand, many of our member hospitals are the major sources for care in their respective communities and have strong primary care and family practice traditions.

Sixty percent of the residents and interns trained in the United States are trained in our hospitals. Additionally, our institutions train at least three-fourths of all primary care physicians. The common theme for all our member institutions is a major focus on patient care, with education and research seen as supportive to the patient care function. Thus, while having to meet the standards to train physicians, our institutions have a very strong pragmatic, practice oriented focus. This orientation has made community teaching hospitals ideal sites for testing the application of new technique and technology developed in the more academic centers.

Ever since the passage of the prospective payment legislation in 1983 there has been a continuing controversy concerning adequacy of payments to teaching institutions. This debate has been wide ranging, raising questions about the role of the federal government in financing the training of physicians, the means by which the federal government contributes to the training of physicians and whether the payments are too much or too little. There have been many hearings, proposals and a succession of amendments to hospital payments related to the costs of teaching. The general thrust of all the above has been gradual reductions in payments to teaching institutions.

President Bush's budget proposals to the Congress call for still additional reductions in the financial support provided by Medicare to teaching hospitals. We believe his proposals are too extreme and could do serious, long term damage to the affected institutions and to training programs for our nation's physicians.

The ultimate effect on patients would be greater costs (for residents and interns provide a service that would cost much more without them), limiting of access as capacity is reduced, and a reduction in care quality because of the constraint on resources.

Our nations care delivery system is highly pluralistic. National legislation that treats all as if they were the same can have serious unintended consequences. We believe this to be the case with the President's proposals. There is general agreement that we need more primary care and family practice physicians, yet the net effect of the continued accross-the-board cuts could be to lead to the closure of teaching programs where much of the training for primary care and family practice is provided.

All of the various studies concerning hospital financial viability demonstrate that the system has gone to one of very tight financial margins or outright losses. The effectiveness of the prospective payment system as cost control mechanism is now proven. However, its effectivness as a rational way to reimburse hospitals for their costs is far more problematic. The passthroughs for capital, graduate medical education and the costs associated with teaching institutions have all aided in lessening some of the more irrational effects of the prospective payment system. However, the cuts in the passthrough payments to less than costs has added to the difficulty of maintaining fiscal viability in the face of the cost reductions in the diagnostic related group payments. Many hospitals are now at financial risk because of inadequate Medicare payments in the aggregate.

A continuation of past policies will lead to serious disruptions in our health care system, many of which will be in those areas where the nation can least afford it--our rural areas and our inner cities. We need to pause and rethink about how we can produce the kinds of health manpower our nation needs, see that these resources are available where needed, and how to pay fairly for these resources, including their initial training and maintenance. Community teaching hospitals stand ready to contribute to such a debate.

STATEMENT OF THE ASSOCIATION OF PROFESSORS OF MEDICINE

Mr. Chairman and Members of the Subcommittee:

The Association of Professors of Medicine (APM) appreciates the opportunity to submit its views on the important issue of federal support for graduate medical education (GME). We are happy to assist the Subcommittee in its inquiry in this area, which has a major impact on the present and future health of all Americans. We ask that this statement be included in the record of your April 11 hearing.

Representing the Chairmen of the departments of medicine at our nation's 127 medical schools, the APM is interested and concerned with any changes in federal policy for support of graduate medical education. All APM members are involved to a major degree with the training of interns and residents, as they are directly responsible for the internal medicine residency programs at their principle teaching hospitals. Thus, the subject of your April 11 hearing is of great interest to the APM.

The APM will comment on two aspects of the graduate medical education issue. The first is the adjustment factor used in calculating indirect medical (IME) payments. The second, and main focus of our statement, is the issue of support for GME training in the subspecialties of internal medicine. This latter issue is a topic upon which the APM provided substantial input to the Subcommittee in 1985, when the most recent changes in the policy towards support of subspecialty training were made.

In regard to our first area of concern, the Association would like to urge the Subcommittee to proceed cautiously in making any changes in the adjustment factor used in calculating indirect medical education (IME) payments. As data presented to the Subcommittee by the Association of American Medical Colleges shows, the financial health of many of our nation's major academic medical center hospitals is in jeopardy. Further, the data shows that a reduction in the IME adjustment factor on the order called for by the Bush Administration would have a substantial negative impact on major teaching hospitals. The APM urges you and the Subcommittee to take into account the implications such changes in IME payments would have on the large percentage of Medicare patients served by major teaching hospitals before making any changes in either the actual level of IME payments or the policies which underlie them. In addition, we urge you not to minimize the legitimate extra costs associated with training interns and residents have on such facilities.

We would now like to turn to the main focus of our statement, support for GME training in the subspecialties of internal medicine. The APM wishes to make very clear that our comments are only relevant to the medical subspecialties -- allergy/immunology, cardiology, endocrinology, gastroenterology, hematology/oncology, infectious diseases, nephrology, pulmonary medicine, and rheumatology -- and not to other subspecialty fields such as those in surgery or orthopedics.

As the Subcommittee is aware, the Omnibus Reconciliation Act of 1985 (P.L. 99-272) substantially changed the policy for reimbursement by Medicare of direct medical education costs. In addition to changing the way such payments are calculated (from a pass-through basis to a hospital-specific per-resident amount), the Act also limited full Medicare support for the costs of GME training to the amount of time necessary for a resident to achieve initial board eligibility, plus one year but not exceeding five years. Thereafter, residents would be supported by Medicare for 50 percent of their allowable GME costs. Thus, major changes have recently been made in the actual level of support for subspecialty training.

The APM accepted this policy only as a compromise from the original Senate proposal to eliminate all GME support beyond initial board eligibility. The Association believed then and continues to believe now that training in the subspecialty fields of internal medicine is important to: the continued advancement of medical science; the patient care needs of major teaching hospitals and academic medical centers (where the majority of Medicare beneficiaries receive in-patient care); clinical research efforts; and, the education of medical students in the primary care fields of internal medicine, family practice, and general pediatrics.

No reliable and up-to-date data exists to our knowledge that shows that medical subspecialties constitute a significant portion of any present or projected oversupply of physicians, and in fact there is evidence that the present supply of subspecialists may not be adequate. Indeed, Dr. William Schwartz, Professor of Medicine at Tufts University, and a research team from the Rand Corp. concluded in a recent study of physician supply, that there now exists and will continue to exist a shortage of medical subspecialists, especially in medium-sized cities. Dr. Schwartz and his colleagues believe that increased demand due to population growth, aging of the population, advances in technology, and increased income will require more subspecialists than had been earlier projected. Others have also revised estimates of the projected demand for medical subspecialists in practice, based on a greater number of such physicians entering research, administration and other non-clinical fields, as well as diminishing numbers of students choosing internal medicine as a specialty.

Also, APM believes it is important for the Subcommittee to be cognizant of the fact that an adequate supply of medical subspecialists is a critical element in caring for our increasingly aging population, as these physicians provide a significant amount of the medical services delivered to Medicare beneficiaries. Treatment for many diseases which afflict primarily the elderly, such as certain types of cancers and renal ailments, and degenerative conditions such as arthritis, are treated almost exclusively by medical subspecialists. In fact, data from the Robert Wood Johnson Foundation demonstrates that nearly three out of ten outpatients seen by medical subspecialists are 65 years of age or older. Given the conclusions of Dr. Schwartz, it would seem unwise to further discourage physicians from entering fields which are so critical to many Medicare beneficiaries.

Given the fact that the impact on Medicare beneficiaries of the greater than 1/3 reduction in the level of actual payments for subspecialty training called for in the 1985 Act can not yet be accurately assessed (as the provisions of the Act are not yet fully implemented), as well as the other evidence presented here, the APM strongly urges you and your Subcommittee to make no changes in the current policy for support of subspecialty GME training. The Association believes that the current one year of full support is critical to meeting the present and future health care needs of our country, and that any changes in this policy would have a very harmful effect on our population, especially the aged, and on efforts to recruit medical students to needed medical subspecialties.

The APM thanks you for this opportunity to present our views to the Subcommittee, and reiterates its desire to assist you in any way it can. Should you have any questions, please call Mr. Jim Terwilliger, APM's Director of Government Relations, at (202) 857-1158.

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April 19, 1989

The Honorable Fortney Stark
Chairman
House Committee on Ways & Means
Subcommittee on Health
1114 R Longworth House Office Building
Washington, DC 20515

Dear Mr. Chairman;

The Association of Program Directors in Internal Medicine (APDIM), the principal organization of residency directors for the nation's 422 residencies in the specialty of internal medicine, are concerned about both direct and indirect medical education payments to the nation's hospitals. The Administration has proposed decreasing the indirect factor from approximately 7.7% to 4.05% for every 0.1 increase in the ratio of residents to beds in teaching hospitals. APDIM is concerned that this decrease in payments that are intended to recognize the increased costs of care in teaching hospitals will be insufficient. The Association of Program Directors in Internal Medicine represents physicians who do not receive financial support from these indirect medical education payments, but are concerned about their impact on the quality of care and education in the nation's teaching hospitals.

Apparently, part of the rationale for the decrease in the indirect payment has been the observation that many teaching hospitals showed surpluses during early years of the Prospective Payment System. We believe that this reflects, at least in part, the response of these hospitals to the very purpose of the Prospective Payment System, that is, to provide hospitals with financial inducements to operate more efficiently. However, it is also possible that these surpluses resulted from indirect medical education adjustment levels that were higher than appropriate. Even if this were the case, the Association of Program Directors in Internal Medicine believes that the precipitous drop in the indirect medical education adjustment from 11.59% to the present 7.7% has occurred more quickly than would allow for the adequate evaluation of its impact. Indeed, many teaching hospitals, particularly in the Northeast, are now suffering losses that threaten their ability to continue to provide high quality care. These institutions are often the major referral centers in their regions, provide large amounts of indigent care, and assure high quality education to future physicians.

The Government Accounting Office has developed four models of the cost factors which account for the higher costs of teaching hospitals and has recommended that the indirect Graduate Medical Education payment should be 5.09%. The Prospective Payment Commission has recommended that this figure should be 6.6%. APDIM is puzzled by the inconsistency among the results of the different analyses. APDIM believes that any decrease in the indirect medical education adjustment is ill-advised. We suggest that further refinement of the indirect Graduate Medical Education adjustment should not be made until the full impact of 100% prospective payment has been observed.

The Association of Program Directors in Internal Medicine is also deeply concerned about the viability of the direct medical education payments under Medicare. Some of these concerns are outlined in the accompanying policy statement from APDIM on the financing of ambulatory graduate medical education. APDIM recognizes the concern on the part of Congress that the possibility of a surplus in the number of physicians raises questions about the wisdom of governmental support of medical education. APDIM points out that there are a number of specialties in which surpluses do not exist, including general internal medicine (as stated by the Council on Graduate Medical Education), but that federal financing of graduate medical education should not be dependent upon a shortage of physicians. The cost of medical education is a normal cost of medical care, just as research and development are normal costs of other services and products and are interwoven with the cost of these products. However, the cost of graduate medical education is somewhat different from normal commercial products, since it is a social good; that is, the benefit of the medical education carried out in the nation's teaching hospitals benefits other hospitals, other health care providers, and the nation as a whole. Concern about the number of physicians and their specialty distribution are certainly important, but payment for medical education also assures the high quality of future physicians in this nation.

The Association of Program Directors in Internal Medicine believes that the cost of medical education should be borne not only by Medicare, but by all payors for health care, and not only by teaching hospitals. Reform of payment for graduate medical education should focus less on the details of the dollars per resident paid by Medicare and more on fundamental issues such as widening the responsibility for payment for graduate medical education, and encouraging innovation in medical education and adaptation to the changing nature of health care, particularly its movement the ambulatory setting.

We would be please to offer our assistance as the Subcommittee continues its consideration of these issues. In addition, we respectfully request that this letter and the attached materials be made a part of the record of the April 11, 1989 hearing on financing graduate medical education.

Sincerely,

John M. Eisenberg
John M. Eisenberg, M.D.
Chairman
Public & Legislative
Policy Committee

Attach: 1

cc: Council & P&L Committee
Members: Subcommittee on Health

FINANCING INTERNAL MEDICINE TRAINING IN AMBULATORY CARE

Association of Program Directors in Internal Medicine
November 1988

The Association of Program Directors in Internal Medicine (APDIM), whose members include over 800 individuals representing 95% of the nation's 442 accredited programs in Internal Medicine, declares that major changes are needed in the financing of Internal Medicine training programs in ambulatory care. Traditionally, resources and funding for medical education have been allocated primarily on the basis of inpatient service needs. Consequently, outpatient training programs have been underfunded and dependent upon subsidized support.

Recent changes in payment policies and in hospital utilization have exacerbated the need for both high quality ambulatory care services and training programs. Prospective payment of hospitals and managed medical care systems have led to continued decreases in hospital lengths of stay. In addition, improvement and dissemination of diagnostic technology has enabled patient evaluations, previously requiring hospitals stays, often to be performed in ambulatory setting. Consequently, inpatient experiences, without a major component of ambulatory care training, can no longer provide adequate exposure to the complete spectrum of diagnostic and therapeutic elements of Internal Medicine.

A major obstacle to the development of educational programs in ambulatory care has been the failure of the payment system to fully compensate for the educational costs of postgraduate training in ambulatory settings. Adequate financing is essential for the next generation of physicians to practice high quality, cost effective medicine that is comprehensive and responsive to patient needs.

Recognizing that increased funding will be necessary to implement revised requirements by the Residency Review Committee in Internal Medicine which call for increased ambulatory care experiences during residency training, APDIM has developed the following policy position and action agendas:

POSITION 1:

Ambulatory care training should be adequately financed, and the cost should be borne equitably among all health care payers.

RATIONALE:

Medical education institutions have financially subsidized education in ambulatory care, but increased financial support cannot be expected in an environment of restricted physicians' fees and curtailment of support for research and education without entailing major sacrifices. Although we maintain that funding for ambulatory care training should be given very high priority, we do not believe that this should be accomplished at the expense of diminishing academic medicine's responsibilities for service to the indigent, medical research and medical student education.

Graduate medical education in Internal Medicine ambulatory care involves training experiences under supervised conditions in which physicians-in-traininng directly provide patient care services. The service rendered by residents represents a substantial portion of the already work week, but as is the case with all graduate medical education, it has been virtually impossible to separate the educational from the service components of patient care provided by medical residents-in-training. Patient care revenues are an important and appropriate source of funding for graduate medical education. However, at present residents' service responsibilities to justify hospital support of their salaries are strenuous and focused on hospital inpatient services. As legislators, regulators and medical educators all attempt to reduce house staff service hours, the flexibility of their schedules will decrease and they will potentially have even less time for educational pursuits. This will be exacerbated if there are no reductions in patient service responsibilities demanded by hospitals in exchange for residents' salaries paid through hospital revenues.

One of the reasons for this burden on teaching hospitals to support residents' salaries and associated expenses is that while all communities and hospitals benefit from having physicians who are appropriately trained in ambulatory care, ambulatory care training is not provided in all communities, nor at all health care facilities. The educational costs of ambulatory graduate medical education, therefore, are generally absorbed in disproportionate amounts by those institutions providing these educational programs, by some third-party health care payers (e.g. Medicare), by other government agencies, and by some patients and other tax payers (in the case of public hospitals) of the communities served by the teaching facilities.

Meanwhile, nonteaching hospitals, most health maintenance organizations, and many third-party payers do not pay their fair share of the educational costs. By loading so much of the burden for all graduate medical education on so few payors and providers, the opportunity to offer important elements of clinical training, such as ambulatory care, is limited. Even within teaching facilities, the financing of ambulatory care training is often inadequate and revenues are generally distributed unevenly among educational programs.

ACTION AGENDA:

1. The profession must take a leadership role in seeking to better determine the costs of graduate medical ambulatory care training. The profession will need to work cooperatively with government and other third party payers in examining why the costs of patient care services are higher at teaching facilities than at non-teaching institutions. The profession will also need to recommend how much of the additional cost of ambulatory training should appropriately be attributed to education.

2. Accounting methods utilized by teaching facilities should be modified to reflect identifiable costs of ambulatory care training. Routine and customary overhead figures reflecting costs of a 24-hour per day, 7-day per week in-hospital service may not be appropriate for the more limited hours of operation of an ambulatory care training site. Therefore, Program Directors will need to work constructively with hospital directors to re-evaluate costs attributed to ambulatory care sites.

   For example, the revenues generated for the hospital and other physicians by patients referred from or admitted from the ambulatory care training site should be calculated to determine whether these hospital and staff revenues could be used to support ambulatory education.

3. Medical educators must assume responsibility for developing cost-effective ways of educating residents both in inpatient and outpatient settings.

4. The costs of medical education and training should be considered as part of the cost of providing patient care, and therefore should be reflected in a resource-based relative value scale to pay physicians. Development and implementation of a resource-based relative value payment system should then be supported as a means to achieving improved equity both in payment for physician services and in sharing the burden of paying for medical education.

5. Medicare payment rates, including capitated payments to health care delivery systems such as health maintenance organizations, should contain components for the costs of graduate medical education regardless of setting. Consideration should be given to allowing additional financial support to institutions (including HMOs, and physicians' offices) providing ambulatory care training. We recognize that these increases may need to be implemented by the Federal Government within constraints of budget neutrality.

6. Medicare should include time spent by housestaff in outpatient training for both direct and indirect education cost payments regardless of whether the training site is operated by the hospital or by an independent facility (e.g. a clinic), as long as the training is part of an accredited program. Direct payment for Medicare patients should receive reimbursement for ambulatory education on the same basis relative to resident and faculty effort in ambulatory education. Reimbursement should not be dependent on the hospital's historic costs as reported prior to introduction of the Prospective Payment System.

7. Medicaid payments should include payment for education and training in ambulatory and outpatient settings.

8. New sources of support should be explored to spread the costs of education across all payors and all sites of care. APDIM and its members will work toward the development of a payment system in which all public and private health care payers contribute toward the costs of graduate medical education.

POSITION 2:

Financing from sources other than patient care revenues is and will continue to be needed to support primary care residency programs, particularly those providing ambulatory care training experiences.

RATIONALE:

Although patient care revenues provide some support for hospital-based medical education, they are rarely, if ever, sufficient to fully compensate teaching facilities for the higher costs associated with running an ambulatory care training program. Even if reform of payment for graduate medical education were to provide support less tied to inpatient service and sufficient to support ambulatory training, additional funds would be needed to develop innovative educational approaches, to train educators, and to support elements of ambulatory education that are not patient based. Additional funding would also be required to finance training in which residents cannot contribute efficiently to patient care (i.e. brief rotations on non-medical specialties, conferences, teaching regarding ethics, etc.). Grant support will continue to be needed for program planning and curricula development, traineeships and fellowships, and for faculty development.

ACTION AGENDA:

1. Authorization levels for federal Title VII funds for primary care residencies should be increased and annual appropriations should be stabilized or also increased.

2. Federal faculty development grants for ambulatory care training in primary care programs should be increased and stabilized. In addition, new funding should also be identified to develop ambulatory care educators in non-primary care settings.

3. State support should be sought for ambulatory care residency training in all primary care disciplines. States should be encouraged to adopt or continue programs that provide financial support for primary care residency training in return for service commitments by trainees.

4. Medical institutions will need to subsidize ambulatory care training from revenues gained other more remunerative services.

5. Employers, community groups, and philanthropists should be informed of the value to the community of ambulatory care training and should be encouraged to provide financial support.

Prepared by the APDIM Public and Legislative Policy Committee, November 1988, John M. Eisenberg, M.D., Chairman.
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April 19, 1989

Robert J. Leonard, Chief Counsel
Committee on Ways and Means
House of Representatives
1102 Longworth House Office Building
Washington, D. C., 20515

Dear Mr. Leonard;

The purpose of this letter is to make a statement in relation to the House Ways and Means Committee hearing held on April 11,1989, regarding graduate medical education under Medicare. The Los Angeles County Department of Health Services urges you not to reduce federal support for graduate medical education programs.

Based on the Administration's proposed budget for 1989-90, Los Angeles County hospitals now project a $2.1 million deficit for the graduate medical education program. Underfunding and weakening of that program could reduce the number of interns and residents available to the county hospitals. The county would either have to replace these personnel with physicians at more than double the salary or reduce services. The proposed reduction in indirect medical education from 7.7% to 4.05% would result in a further loss of $3.3 million in 1989-90.

Reduction of federal commitment to medical education would further compound the financial problems which our hospitals are experiencing due to other changes in federal reimbursement methods.

For example, the change from Tax Equity and Fiscal Reform Act (TEFRA) to the diagnosis-related group (DRG) reimbursement method is causing increasing losses to our systems each year. The DRG method, which allows recovery of only two-thirds of our cost, will produce $2.2 million less revenue in 1988-89 than the TEFRA method would have given. We expect a $3 million difference between the two methods in 1989-90.

Further, reimbursement to the county for prospective payment system (PPS), TEFRA and capital related costs has been an average of $9 million lower than cost for the past two years. Similar losses have occurred in previous years and the 1989-90 loss for these factors is projected at $14 million.

Disproportionate share and indirect medical education payments have helped offset these losses in prior years, but enactment of the Administration's proposed budget will create a projected $2.3 million net loss for the county in 1989-90 even after these reimbursements.

California counties are the providers of last resort for the health needs of the more than five million Californians who have either inadequate health insurance coverage or none at all. Continued underfunding weakens an already precariously funded health care system. For this reason, we urge you not to adopt any budget measures that would further reduce the revenue of public hospitals.

Sincerely,

Sandra J. Anderson

Sandra J. Anderson
Director of Governmental Relations
wp2.mcare

[BY PERMISSION OF THE CHAIRMAN:]

STATEMENT OF CHARLES R. MODICA, J.D., CHANCELLOR, ST. GEORGE'S UNIVERSITY SCHOOL OF MEDICINE, GRENADA, WEST INDIES

Mr. Chairman and members of the Subcommittee, I am very pleased to appear before you today to discuss graduate medical education assistance under the Medicare program.

St. George's University School of Medicine was founded in August, 1976. Since that time, over 1100 students have graduated with degrees in medicine, with many of them returning to the U.S. to train for practice in underserved areas -- often in inner-city area teaching hospitals that treat great numbers of low income and indigent patient populations eighty to ninety percent of residency patient positions are filled by graduates of foreign medical schools. There would be a significant patient-load burden on many of these hospitals if not for residency slots being filled by graduates of non U.S. schools such as St. George's. The "Journal of the American Medical Association" has reported that St. George's University School of Medicine students had the highest initial pass rate of all the leading foreign medical schools in the world on the U.S. - qualifying examination (the ECFMG). As each class at St. George's finishes its second year of medical education, approximately one-third of that class transfers to U.S. medical schools to complete their education.

Mr. Chairman, I am here today to recommend that any policy changes relative to Medicare reimbursement for Graduate Medical Education (GME) not unfairly single out Foreign Medical Graduates (FMGs), as has been attempted in the past. In 1986, Congress established the Council on Graduate Medical Education, known by the acronym of COGME. COGME is an advisory body comprised of a representative sample of experts in medical education and other academic and medical fields. This Council was asked to issue a report to the Secretary of HHS and Congress to advise them how they should deal with issues related to Graduate Medical Education from the standpoint of public policy. In July of 1988 COGME released its first report of conclusions and recommendations to Congress. Relating to foreign medical graduates the Council has concluded that:

- The principle of individual competency as the dominant criterion for selection into GME should be maintained.

- Differentiation among Foreign Medical Graduates on the basis of citizenship or immigration status is contrary to this principle, as well as to U.S. tradition, and ethical code, and is perhaps illegal.

- It is highly desirable that all graduates of U.S. allopathic and osteopathic medical schools be able to obtain an entering position in GME. However, U.S. medical school graduates should not be granted automatic priority over the qualified graduates of nondomestic medical schools as a means of achieving this goal.

- U.S. medical schools are obligated to provide the best possible education which will allow all graduates to compete effectively for GME positions. They should carefully evaluate all students and graduate only those considered unequivocally qualified for GME.

- It would be both presumptuous and unwise for the government and/or the private sector to attempt to establish procedures for accrediting medical schools outside its territory.

- Unless alternative systems for providing care

are established first, exclusion of FMGs from GME programs will reduce the ability of a small number of hospitals to provide certain essential hospital-based medical services. These hospitals serve a disproportionate share of the poor. Ambulatory services will be most immediately and severely impacted.

- Nonphysician health care providers can perform some of the tasks now provided by FMG residents. However, the degree to which this can be accomplished varies markedly depending on the nature of the specialty and the level of care being provided.

The Council also made the following recommendations:

- Selection into GME programs should be based on the relative qualifications of the individual applicants, not on group or institutional associations.
- For the purpose of limiting access to GME, the Federal Government should not establish policies which would discriminate against medical school graduates on the basis of citizenship, immigration status, or medical school location.
- A single medical knowledge examination for all GME candidates should be implemented as soon as possible.
- If an applied clinical skills assessment examination is introduced for general applicability for entry into GME, one examination should be used in evaluating all candidates, including graduates of U.S. medical schools.
- The private sector should be sensitive to bias in testing which may be caused by use of new testing technologies and methodologies.
- Neither the Government nor the private sector should establish a system for accreditation of foreign medical schools.
- The private sector should endorse and assist the efforts of foreign countries to establish national or regional standards and procedures which will improve education in their medical schools.
- If the Federal Government and/or the private sector were to develop policies which would reduce the number of FMGs in GME, alternative systems for delivering hospital-based medical care should be established in advance for those FMG-dependent hospitals which serve a disproportionate share of the poor.

Mr. Chairman, COGME has made a very comprehensive, complete and non-partisan review of all of the issues, and its conclusions and recommendations are similar to what we have been stressing for several years. The Council has now greatly added credibility to our argument and it is our hope that this important subcommittee will carefully consider its views relative to foreign medical graduates. As well, I believe it is important to mention, that as a trend, the U.S. medical community has begun to recognize past discrimination and to take measures to correct these inequities. For example, based on the resolution adopted by the American Medical Association's Council on Medical Education, the National Board of Medical Examiners has agreed with the Education Committee for Foreign Medical Graduates that there should be one standard test for all medical graduates to determine competency, rather than the two separate tests that are now administered.

Also, the American Medical Association has adopted resolutions opposing discrimination against duly licensed physicians on the basis of education or ethnic background, and has developed model legislation that would prohibit states from discriminating against FMGs.

Thank you very much for the opportunity to present this statement.

VHA.

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Office of Public Policy

April 21, 1989

VIA HAND DELIVERY

The Honorable Fortney Pete Stark
Chairman
Subcommittee on Health, Committee on
Ways and Means
U.S. House of Representatives
1102 Longworth House Office Building
Washington, D.C. 20515

Re: The Administration's Fiscal Year 1990 Budget Proposals to Reduce the Indirect Medical Education Adjustment and Direct Graduate Medical Education Payments Under the Medicare Program

Dear Mr. Chairman:

This letter responds to your invitation for written submissions regarding the Administration's budget proposals to reduce the Medicare Program's indirect medical education ("IME") adjustment and direct graduate medical education ("GME") payments for fiscal year 1990. We would like these comments to be considered by the Subcommittee and included in the printed record of the April 11, 1989 hearing.

Founded in 1977, the Voluntary Hospitals of America ("VHA") has grown into the largest not-for-profit health care alliance in the nation with hospitals operating in 47 states and the District of Columbia. It counts among its members 662 not-for-profit hospitals and 172 affiliate institutions. VHA members operate 16% of the nation's non-federal hospital beds and train nearly 25% of this country's interns and residents.

VHA hospitals constitute nearly 20% of all institutions who receive the IME adjustment. Two hundred and fifteen VHA hospitals have residency training programs and these hospitals spend over $2 billion on these programs. Consequently, VHA very much appreciates the opportunity to comment on the future treatment of the IME adjustment and GME payments under the Medicare Program.

SUMMARY

VHA believes that any reduction in the IME adjustment and direct GME payments including the reductions proposed by the Bush Administration for fiscal year 1990 is inappropriate. Congress has already enacted changes in the IME adjustment and in reimbursement for GME under Medicare which have resulted in hundreds of millions of dollars in savings annually to the Medicare Program. Further cuts cannot be sustained without jeopardizing both patient care to beneficiaries and the training of future health professionals.

Proposed reductions in the IME adjustment and GME reimbursement are particularly troublesome in light of the important role played by teaching hospitals in the delivery of health care in this country. The quality of our health care system is dependent upon the quality of the education its health professionals receive. Teaching hospitals are primarily responsible for the training of our future health professionals. They are often centers for medical research and the clinical proving ground for technological breakthroughs. Teaching hospitals are responsible for rendering care in severe and uncompensated care to the indigent and uninsured. Chipping away at the level of the IME adjustment and GME reimbursement ignores the realities and jeopardizes the ability of teaching hospitals to continue their multi-faceted role as health institutions. Without adequate reimbursement for the costs associated with medical education and the complex and resource intensive work conducted by teaching hospitals, the continued ability of these institutions to fulfill their unique and important role in the health care delivery system will be jeopardized.

IME ADJUSTMENT

As you know, the Administration has proposed to reduce the IME adjustment for fiscal year 1990 from 7.7% to 4.05% Since Congress first incorporated an 11.59% IME adjustment into the Prospective Payment System ("PPS") legislation, that original IME adjustment has been reduced twice, first to 8.1% and then to the current 7.7%. For the reasons set forth below, yet another "hit" to the IME adjustment would be improper.

We believe a reduction in the current adjustment rate would be ill-advised because the adjustment would no longer adequately compensate hospitals for all the costs the adjustment is intended to reimburse. Part of the problem is that the terminology used to identify the IME adjustment -- indirect medical education -- is fundamentally misleading. Since the adjustment's inception, Congress has recognized that the IME adjustment would not simply reimburse teaching hospitals for education and related program costs. Rather, Congress has acknowledged that the IME adjustment would compensate hospitals, in part, for PPS's failure to account for the severity and complexity of illnesses. This inadequacy in PPS is particularly problematic for teaching hospitals since they are often the facilities which have the resources to provide highly specialized services and treatment programs and therefore attract complex cases.

Moreover, as more and more medical care is rendered on an outpatient basis, the cases treated on an inpatient basis increasingly involve severe and complex illnesses. We would also note that the IME adjustment serves as a proxy for other factors beyond traditional educational expenses which increase cost in teaching hospitals. These factors include the greater use of ancillary services, location in innercities, and a more costly mix of staffing and facilities. Thus, "now more than ever" an adequate IME adjustment is needed. This factor is currently the only method available for assuring that teaching hospitals receive sufficient reimbursement for the costs associated not only with medical education but for the costs associated with treating severe and complex cases.

Any evaluation of the adjustment should not be limited to a regression analysis. Instead, as suggested by the Prospective Payment Assessment Commission ("ProPAC"), an empirical estimate of the relationship between teaching effort and Medicare cost per case, using the most recent cost data available, should be used. Only through such an analytic approach will the effect of teaching effort on Medicare cost per case be adequately compensated.[1/]

Finally, as suggested by ProPAC, the equities of Medicare payment distribution to hospitals, as well as the financial impact of reductions in the IME adjustment for teaching hospitals, should

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[1/] While we endorse an evaluation of the IME adjustment based on an analysis similar to that suggested by ProPAC, we do not endorse ProPAC's proposal for reducing the IME adjustment to 6.6% for fiscal year 1990.

be addressed in evaluating the IME adjustment. An assessment of the financial impact of reducing the current IME adjustment rate is particularly critical in light of recent VHA data demonstrating that the early success of teaching hospitals under PPS was short-lived. Specifically, while teaching hospitals may in the past have had significantly higher Medicare margins than non-teaching hospitals, our data indicates that this is no longer true. Indeed, our projections indicate that teaching hospitals, as a group, are now experiencing the same very low or even negative margins experienced by non-teaching hositals. These projections further show that by fiscal year 1990, under current law, most teaching hospitals in VHA will lose money serving Medicare patients. Further reductions in teaching payments will significantly worsen an already serious financial situation for this country's teaching hospitals. Moreover, it will put teaching hospitals at a competitive disadvantage vis-a-vis non-teaching hospitals. That inequitable result runs counter to the very purpose of the IME adjustment.

DIRECT GME PAYMENTS

The Administration has proposed similarly inappropriate budgetary reductions with regard to direct GME payments. It has proposed that Medicare reimbursement for the direct costs of physician graduate training exclude costs other than those related to the salaries of interns and residents. The payments subject to elimination under the Administration's proposal include those for classroom costs, the costs of supervising faculty salaries, and allocated overhead.

This proposal should be rejected because the effect of the Consolidated Omnibus Budget Reconciliation Act of 1985's ("COBRA's")[2/] change in the method of payment for physicians in graduate training is yet to be determined. As you know, COBRA required the development of a new payment methodology for GME costs, i.e., a hospital-specific approved per resident payment amount based upon a hospital's historical allowable GME costs for its cost reporting period beginning during federal fiscal year 1984. This new payment methodology represents a significant change in payment for GME costs under the Medicare Program, as GME costs were formerly reimbursed on a reasonable cost basis.

The Health Care Financing Administration ("HCFA") did not release proposed regulations until nearly two and one-half years after the effective date of the new statutory provision[3/]. Moreover, those regulations have yet to become final and HCFA intends to retroactively implement the new statutory provision. Until such time as the impact of this new method of payment becomes known and a reasoned assessment of that impact is possible, it is inappropriate to further reduce direct GME payments.

Indeed, even HCFA expects that the new GME payment methodology, if applied retroactively as set forth in the proposed regulations, will reduce hospital payments by a total of $500 million in fiscal

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[2/] Section 1886(h) of the Social Security Act was addressed by Section 9202 of COBRA and amended by Section 9314 of the Omnibus Budget Reconciliation Act of 1986 ("OBRA").

[3/] Fed. Reg. 36,589 (1988) (to be codified at 42 C.F.R. pts. 405, 412 and 413) (proposed Sept. 21, 1988).

year 1991. This amount is twice the amount Congress intended to reduce hospital payments by when it changed payment methodologies.[4] According to the Congressional Budget Office, this amounts represents 42% of total Medicare reimbursement for GME direct costs. Thus, payment reductions of the size expected by HCFA will have a devastating impact on teaching hospitals. This reduction in payments to teaching hospitals is even more significant as it comes at a time when, as discussed above, teaching hospitals are operating on narrowed margins.

* * *

In conclusion, the proposed reductions in the IME adjustment and GME payments would undermine support for both the costs associated with medical education and the complex and resource intensive care rendered by teaching hospitals. It is ill-advised to destroy the Medicare Program's current support system for medical education before a substitute system is in place.

Thank you for your consideration of our views.

Sincerely,

Daniel P. Bourque
Corporate Senior Vice President

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[4] According to estimates provided by the Congressional Budget Office at the time COBRA was enacted, the new GME payment methodology was expected to produce savings of $250 million in fiscal year 1991.

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